

Susquehanna OB/GYN and Nurse Midwifery
www.sogmd.org

Financial Agreement

Patient Name: _____ **DOB:** _____ **Date:** _____

Dear Patient,

Thank you for choosing Susquehanna OB/GYN and Nurse Midwifery for your healthcare needs. We value our relationship with you and would like to tell you about the financial aspects of our services. Some of the information outlined within this policy include our obligations to comply with insurance, Federal, Privacy and Fair Collections Acts. Your financial responsibilities related to your healthcare are included as well.

Red Flags Rule

The Federal Trade Commission developed a set of rules to protect consumers against identity theft. In order to protect your identity we require a photo ID & Insurance Cards at each visit.

HIPAA

In compliance with HIPAA regulations, we are unable to discuss details of services rendered or to produce an itemized bill for any parties that are not the patient, unless authorized in writing by the patient.

Medical Fees and Payments

Fees are based on the complexity of your visit or procedure. Unmet Deductibles, co-payments and outstanding balances are due at the time services are rendered. We accept Visa, Master Card, cash, personal checks and money orders. We accept secured payments over the phone at (410) 939-9569.

Form Completion & Medical Record Copying Fees

We charge \$25.00 for the completion of forms including but not limited to Disability documents. We also adhere to Maryland State Medical Records copying fees outlined in our Medical Records Copying Protocol.

Missed or Cancelled Appointments

As a courtesy to other patients who need to be seen, if you need to cancel your appointment please call at least 24 hours in advance. Excessive no shows may result in dismissal from the practice.

Returned Check Charge

Non-Sufficient Funds (NSF) are subject to a \$36 fee (in addition to fees from your bank). Cash payments will be expected after more than one NSF fee.

Self- Pay Patients

Our practice will give you an estimate of what will be due. Sometimes it is medically necessary to add services. When this occurs, our Providers will notify you. Payment for all services are due at your visit. There might be instances in which you are billed for the services added to your visit.

Payment Plans

In some instances, our office will work with you to develop a plan to assist you in paying outstanding balances with our practice. Contact our billing department at (410) 939-9569.

308 Union Ave, Havre de Grace, MD 21078
520 Upper Chesapeake Drive, Suite 301, Belair, MD 21015

Phone: (410) 939-3121
Phone: (443) 643-4300

Minor Patients

Parent(s) or guardian(s) accompanying a minor for medical services are responsible for providing insurance information and payment of the services rendered to the minor child.

Obstetrics Global Care

To assist our OB patient’s with understanding insurance benefits we will verify your coverage. Sometimes your insurance will leave you with an out of pocket expense. We allow a monthly payment plan to help you take care of this balance. Full payment is expected prior to anticipated delivery date.

Non-Payment of Outstanding Accounts

We make many efforts to assist our patients with managing their medical bills. Please contact us if you are having difficulty with payments. Accounts that are not paid in a reasonable amount of time will be sent to an external collection agency. Should the account be referred to a collection agency or an attorney for past due amounts, the patient shall incur attorney’s fees, court costs and all applicable collections expenses.

Referrals

Some insurance carriers may require you to obtain a written referral from your primary care physician for specialty services. We will only perform services and file claims for authorized services based on your insurance carrier’s guidelines. Payment for unauthorized services will be due at the time service is rendered.

Assignment of Insurance Benefits and Third Party Claims

By signing this document you authorize benefits from your insurance company to be made on your behalf to Susquehanna OB/GYN & Nurse Midwifery for services furnished to you by our providers. You also authorize release of your medical information necessary to process insurance claims on your behalf. If you do not agree with this then our office will be unable to submit insurance claims on your behalf and payment in full will be expected prior to services being provided.

Financial Attestation

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of any services provided to me. Payment is due at the time services are rendered which includes co-payments, deductibles, and co-insurance with my carrier.

I have read both sides of this document and agree to the terms. I will notify the office of any changes in my personal and billing information.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Parent of Minor: _____

Date: _____