Healthcare For Women
OBSTETRICS and GYNECOLOGY

1625 N. George Mason Drive, Suite 474, Arlington, VA 22205
1875 Campus Commons Drive, Suite 110, Reston, VA 20191

FINANCIAL POLICY

Thank you for choosing us as your Gynecologist/Obstetrician. We are committed to render the best health care to our patients. The following is information regarding our financial policy. We would like for you to read and sign accordingly.

INSURANCE
If our physicians participate with your insurance company, we will file for insurance benefits and accept payments per our contractual agreements with the insurance company. **The patient MUST provide a valid insurance card AND a valid US Government issued ID**. When applicable, the patient is responsible for co-pays, deductibles or co-insurance at the time services are rendered. Any questions or disputes concerning coverage or payment of benefits, is a matter between the subscriber/policy holder and the insurance company. Any assistance in this matter granted by our practice is given strictly as a courtesy and implies no responsibility on our practice for the charges incurred by the patient. It is your responsibility to notify this office of any changes in your insurance coverage at the time of the visit.

If our office does not participate with your insurance company, you must make payment in full at the time services are rendered - NO EXCEPTIONS. The same applies to self-pay patients. We accept payments by cash, debit cards, VISA, MASTERCARD, DISCOVER, and American Express.

If your insurance requires a referral/authorization for services, it is your responsibility - as the patient- to obtain the referral/authorization from your PCP prior to your visit. If you do not obtain the proper referral/authorization and receive services, you will be responsible for all charges incurred. Should you choose to receive services without the required referral/authorization number, you will be held responsible for any charges incurred.

It is your responsibility to know if our physicians participate with your insurance plan. Also, it is your responsibility to know your plan policy in regards to all laboratory procedures and all screening or diagnostic testing. Failure to notify our office of your plan requirements will result in the patient incurring separate charges from these service providers.

PAYMENT POLICIES
Payment of your balance for non-covered services is due within 30 days of the insurance payment or denial. If our practice does not receive benefit payments from your insurance company 60 days from the service date, the charges will be the responsibility of the patient. **Remember: the contract is between you and your insurance company, not this office**. If your balance is 90 days old -or greater- from the service date, the account will be evaluated to be turned over to a collection agency or attorney for handling. Possible actions by the collection agency or attorney may include credit reporting and legal pursuit of payment. Please understand that you may be responsible for fees/charges incurred by the services provided by the collection agency/attorney.

This office does not accept personal checks unless paying a balance due through the mail. For your convenience, we accept cash and debit/credit card. We accept Visa, Mastercard, Discover and Amex.

RETURNED CHECK POLICY: checks that are returned by the bank for insufficient funds or stopped payments will have a fee of $50 added to the patient's account. This will also result in our inability to accept future personal checks on the account.

FEES

Co-pay not made at time of service	$10	Returned check/stop payment	$50
Lost prescription replacement	$15	No show/missed appointments	$50
Forms/letter of disability	$35	Surgery cancellation within a week of treatment	$100
Medical records processing	*based on number of pages plus shipping and handling fees*		

CERTIFICATION
I certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my current insurance carrier. I also certify that I have read the above financial policy. I understand and fully accept the terms therein.

Patient's Signature: _____ Date: _____