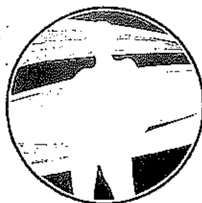

PREMIER OBGYN NAPA

Thank you for choosing Premier ObGyn Napa Inc.! We strive to give the best possible care at the most reasonable cost to our patients. Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancellations and missed appointments., methods of payment, insurance reimbursement, and past due accounts. If you have any questions, please ask your provider prior to signing this Agreement and Policy.

CONSENT FOR RELEASE OF INFORMATION

I give *Premier ObGyn Napa Inc.* permission to release all information necessary to secure payment of benefits related to my care. I also agree that a photocopy of this agreement may be used as the original. ______(initials)

CONSENT FOR TREATMENT

I approve and agree to procedures necessary for diagnosis and treatment for myself while a patient at *Premier ObGyn Napa Inc.* ______(initials)

AUTHORIZATION TO REVIEW PHARMACY

I give *Premier ObGyn Napa Inc.* permission to view my prescription history from outside sources. ______(initials)

CONSENT FOR RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF (valid for 2 years)

I approve that the person named below may pick up or receive medical information about my MEDICAL TREATMENT at *Premier ObGyn Napa Inc.* ______(initials)

( )Lab results ( )Substance Abuse Treatment ( )Prescriptions ( )Other______________________

Name: ______________________________ Relationship: ______________________________

NOTICE OF PRIVACY PRACTICE

I agree I have received/been offered a copy of the NOTICE of Privacy Practices. ______(initials)

PAYMENT

Copayments must be made on the day of service. Accepted methods of payment are cash, check, Visa, Mastercard, American Express or Discover. Checks should be made payable to *Premier ObGyn Napa* Inc. Please call us if you cannot make your scheduled appointment.

ADDITIONAL FEES

- Medical Records - $15
- Disability/FMLA/Medical Clearance Forms - $20
- Late cancellations/Missed appointments – fewer than 24hrs prior to appointment - $25
- Checks returned due to insufficient funds - $25
- Past due accounts over 30 days - $25 per month (unless a prior payment arrangement has been made)

INSURANCE REIMBURSEMENT

Premier ObGyn Napa Inc. accepts and processes insurance payments through a variety of insurance providers and employee assistance plans. If you are using insurance or employee assistance plans to pay for our services, then we will:

- Expect and accept payment of your copayment amount at the time of service
- File your claim with the insurance provider you have given us
- Receive your payment from your insurance provider
- Bill supplemental insurance for our Medicare patients
- **Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment**

PLEASE NOTE

Premier ObGyn Napa Inc. files insurance as a courtesy to you and that you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible to pay *Premier ObGyn Napa Inc.* for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owner of *Premier ObGyn Napa Inc.*

I agree to (1) allow *Premier ObGyn Napa Inc.* to bill my insurance directly for services provided under the outpatient services agreement; (2) give *Premier ObGyn Napa Inc.* permission to release any information the insurance company may require in order to process payment; appoint *Premier ObGyn Napa Inc.* as my authorized representative to act for me in obtaining payment; (3) assign all my rights to claims and payment by my insurance to *Premier ObGyn Napa Inc.*; and (4) agree to assist with the claims process as required by *Premier ObGyn Naps Inc.* or my insurance provider. **I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full fee until the required deductible amount has been met.** I acknowledge that not all issues, conditions and problems dealt with in obstetrics/gynecology are reimbursed by insurance companies.

Patient Name: (printed) ____

Patient/Guardian Signature: ____

PRIVATE/SELF-PAYMENT FOR SERVICES

I will self-pay for services at Premier ObGyn Napa Inc. I agree to the fee schedule that will be provided to me with this document. I understand that payment for services is due at the time services are provided.

Patient Name: (printed) ____

Patient/Guardian Signature: ____

CANCELLATIONS & MISSED APPOINTMENTS

Insurance carriers will not pay for late cancellations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancellations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule, please give us as much notice as possible. You may notify our office by phone or email or the patient portal. Late cancellations or missed appointments will incur a fee of $25.

PAST DUE ACCOUNTS

Amounts past due by more than 30 days will incur a late fee each month of $25 unless a prior payment arrangement has been made. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, *Premier ObGyn Napa Inc.* may resort to legal means to secure payment. This may involve hiring a collection agency or an attorney. If such legal action is necessary, you will be responsible for those costs. Past due accounts exceeding 90 days will be handled by a third party collection agency.

Patient Name (printed) ____

Patient/Guardian Signature ____

CREDIT CARD ON FILE

Upon scheduling your first appointment, you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, or past due account balances. A receipt will be emailed to you at the address you specify below at your request or by mail.

Type of card (please circle one)

VISA * MASTERCARD * AMERICAN EXPRESS * DISCOVER

Card # 16 digits: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration: __ __

CVC code: __ __ __

Name on Card: ____________________________________

I authorize Premier ObGyn Napa Inc. to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature: ___________________________________ Date: ______________________

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below, I agree to be bound by its terms in association with outpatient services provided to me by *Premier ObGyn Napa Inc.* Any and all negotiated exceptions or special arrangements are listed below or attached and require approval and are not valid unless signed by a representative of *Premier ObGyn Napa Inc.*

Patient Name: (printed) ______________________________________

Patient/Guardian Signature: __________________________________

Date: ____________________