Concord OB/GYN Patient Financial Policy

We have adopted the following financial policy to avoid any misunderstanding between you and this office. Our billing department is available 7:30 AM to 3:30 PM to discuss any questions you may have regarding your insurance or your account at Concord OB/GYN. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please call our billing department at 978/371-0302 x 1202.

Please return this form to the receptionist once you have reviewed and signed it. A copy will be provided to you upon your request.

Insurance We participate in most managed care plans. If you are insured by a plan we do not participate with payment is required at each visit. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your own coverage. We will process your insurance claim for you if you assign the benefits to us. In other words, you give us permission to bill your insurance company directly and they will pay us directly. You will be responsible for providing correct insurance information at each visit. You are responsible for obtaining referrals for services if required by your plan. All medical treatment and services that are not covered by your plan will be your responsibility. Patients are responsible for all deductibles, co-payments, non-covered services and out-of network services. All co-payments are due at the time of the visit.

No Insurance Coverage Full payment is expected at the time of service. We accept cash, check, Visa and Mastercard. Please note that the amount charged will not include any expenses related to laboratory or ultrasound services.

Minor Patients The adult accompanying the patient and the parent or guardian will be responsible for all services rendered to minor patients.

Delinquent Accounts Payment is due upon receipt of a statement. If your account becomes delinquent, we will make every effort to collect the debt incurred prior to being sent to a collection agency and possibly being dismissed from the practice.

I have read and fully understand the financial policy and agree to the terms.

______________________________	______________________________
Signature of Patient/Guardian	Date
______________________________	______________________________
Name of Patient (print)	Date of Birth