

## Financial Policy Statement

Welcome to Fairfax OB-GYN Associates, P.C., L.A.R, M.D., P.C., R.L.C., M.D., P.C. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. If we are contracted with your insurance company, we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. This includes obtaining any referrals and/or authorizations which your insurance company might require before care is provided.\* All co-pays, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

Should a monthly payment plan become necessary, arrangements can be made through our billing office. Failure to pay for services or adhere to payment arrangements will result in collection activity. All collection costs incurred by Fairfax OB-GYN Associates, P.C., L. A. R., M.D., P.C., R.L.C., M.D., P.C., including attorney fees (at 33 1/3 % of principal balance) and interest in the amount of 1.5% per month accruing 30 days after your last billing, will be the sole responsibility of the responsible party named herein.

In consideration of the services performed by Fairfax OB-GYN Associates, P.C., L.A.R., M.D., P.C., R.L.C., M.D., P.C., you agree to abide by the terms of this Financial Statement.

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**Patient or Responsible Party Signature      Date**

I, \_\_\_\_\_ hereby authorize Fairfax OB-GYN Associates, P.C., L.A.R., M.D., P.C, R.L.C, M.D., P.C., to apply for benefits on my behalf for services rendered. I certify that the information I have provided is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the health insurance I have provided. I permit a copy of the authorization to be used in place of the original. I may revoke this authorization at any time in writing.

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**Patient Signature**

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**Date**

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**Witness**

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**Date**

\*We especially urge you to consult your insurance benefits information if your visit pertains to INFERTILITY. In many cases, INFERTILITY consults and/or treatment will need prior authorization from your insurance company to be eligible for coverage.