MOBILE BAY OB-GYN CENTER, P.C.

STATEMENT OF FINANCIAL POLICIES

1. **Forms of Payment** – We accept cash, checks, MASTERCARD, DISCOVER, VISA and AMERICAN EXPRESS. All fees for which you are responsible should be paid at the time of service. This will include all co-pays deductibles and non-covered amounts.

2. **Collection** – I understand and agree that in the event that my/our account(s) is/are placed with a collection agency, or an attorney for collection, I/we will pay any and all fees and costs associated with collecting, securing or attempting to collect or secure this account. This is to include, but not limited to, collection agency fees, reasonable attorney's fees, publication fees, process server fees and court costs, whether suit is necessary or not.

3. **Filing Insurance** – We routinely file insurance claims for you if your carrier is one with whom we are contracted (Medicare, Blue Cross Blue Shield, United Healthcare, some HMO's and PPO's.)

4. **Surgery/Obstetrical Charges** – Our bookkeeper can help with arrangements if you have extenuating circumstances. Otherwise, it is our routine to collect the patient's portion of surgery and delivery charges prior to the anticipated date. Details of OB charges are explained in a separate pamphlet.

5. **Non-Covered Services** – I understand that most insurance contracts do not cover routine physical examination when the examination is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury. Any services performed simply to "rule out" a condition will not be covered. I agree to accept responsibility for these charges.

I have read and will comply with the Statement of Financial Policies of Mobile Bay OB-GYN Center, P.C.

______________________________ Patient Signature

____________________ Date

(If you are under the age of 21, please list the person responsible for your charges [parent or guardian] along with their address and phone number.)

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Signature of Responsible Party ______________________________

(By my signature, I agree to take responsibility for the charges incurred by the patient in concordance with the office policy.)

CONSENT FOR TREATMENT

Knowing that I require medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in the hospital or office. If a Pap smear or biopsy is deemed necessary, I hereby authorize Mobile Bay OB-GYN Center, P.C. to send a specimen to a suitable outside laboratory for a pathology report.

Legal Signature ______________________________ Date ____________

Legal Guardian ______________________________ Date ____________

(If patient is under age 21)

Witness ______________________________ Date ____________