OB/GYN Associates of Miami

FELLOWS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
DIPLOMATS, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

PLEASE READ CAREFULLY

The following is a statement of our OFFICE POLICIES, which we require for you to READ and SIGN prior to any treatment.

PAYMENTS

- Full payment is due prior to treatment. There will be a **$25** fee assessed if full payment is not received at the time of service.
- Any returned check will incur an additional **$35** service fee plus a **$25** late fee.
- If your account is sent to Collection Agency, the patient/responsible party will assume all collection costs, including but not limited to, collections fees, court costs, interest and legal fees. All unpaid accounts will be reported to the Credit Bureau.
- The parent or guardian accompanying a minor patient is responsible for payment.

CANCELED, RESCHEDULED OR NO-SHOW APPOINTMENTS

- If an office visit appointment is not canceled at least **24 hours in advance**, you will be charged a **$50** fee.
- If an office procedure or ultrasound appointment is not canceled at least 24 hours in advance, you will be charged a **$75** fee.
- If a surgery appointment is not canceled at least **72 hours in advance**, you will be charged a **$100** fee.

INSURANCE

- It is the patient's responsibility to verify with their insurance company that we are participating providers.
- Your insurance may require additional information from you in order to process your claim. If they do not receive this information accordingly, you will be responsible for immediate payment.
- The patient is responsible for obtaining a referral/authorization from the Primary Care Physician of Insurance Company if required.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE OFFICE POLICIES. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH.

Patient name: _____

Patient/Responsible party signature: _____ Date:_____

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