South Shore
Obstetrics & Gynecology
Women's Health Care

FINANCIAL POLICY

INSURANCE – You must provide your insurance card at the time of service, and we ask that you inform us of any changes to your address, phone number, employment status, or insurance coverage. If you do not have the information requested, i.e., insurance cards, we may ask you to reschedule your appointment or pay in full at the time of service. We will only accept Medicaid as secondary insurance to a commercial insurance that we participate with, or Medicare. We do NOT accept Medicaid as a primary insurance and will NOT retroactively bill any service to Medicaid once presented as secondary. We will only accept Michigan Medicaid as a secondary insurance from the date it is presented forward. If circumstances arise that you are only covered by Medicaid; you have the option to waive the Medicaid benefits at our office, or you will be expected to transfer your care to a provider that accepts Medicaid payments.

CO-PAYS, DEDUCTIBLES, & NON-COVERED SERVICES – All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-payments or deductibles as this would be a breach of contract between you and your insurance carrier.

LAB FEES – Any costs incurred from lab tests ordered by physicians that are sent to outside labs, that may not be completely covered by your insurance, will be patient's responsibility.

CLAIM SUBMISSION – We will submit to all insurance companies as a courtesy. If we do not participate with your insurance carrier, you will be expected to pay in full at the time of service as your insurance will reimburse you directly if you have the appropriate benefits for the services performed.

NON-PAYMENT – If your account becomes 90 days past due, you will receive a pre-collection letter. Your medical care is our priority and your compliance with financial responsibilities is appreciated. If, however, your account remains unpaid and we forward your account to an outside collection agency, the account will be assessed a 40% collection fee of the remaining balance.

RETURNED CHECK – In the event that we receive a returned check due to insufficient funds, or a stop payment; a $30 fee will be assessed to your account.

INSURANCE FORMS, MEDICAL RECORDS & DISABILITY FORMS – We charge an administrative fee for completing insurance forms, copying medical records and disability verification forms. We request 7-10 business days to complete.

FORMS OF PAYMENT – We accept CASH, CHECK, MONEY ORDER, MASTERCARD, VISA, DISCOVER, & AMERICAN EXPRESS.

CANCELLATION / NO SHOW POLICY – We ask if you need to cancel or reschedule an appointment, that you do so 24 hours prior to your scheduled time. Our "No Show" policy allows you to miss one appointment. If you should miss a second appointment, a $25.00 charge will be added to your account that must be paid in full before future appointments.

I understand and agree that by signing my *Patient Information Form* I will be financially responsible for services provided to me and all costs of collection incurred by the practice should my account be determined delinquent. I have provided the practice with all of my insurance coverage and will keep this office informed if my overage changes. I have read and understand the policies and how they affect me and my financial obligations to the practice. My signature also indicates that I authorize the release of any medical information necessary to process my insurance claims. I understand and agree that I am responsible for all charges not authorized by my insurance carrier.

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HIPAA PATIENT PRIVACY SUMMARY

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Existing Michigan Law requires (in addition to our attempt to obtain your written consent, described above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation, an identification of a dead body, a licensure investigation; or a child abuse/neglect investigation.

By signing your ***Patient Information Form,*** you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, suck a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand and agree that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practice form.