cedar rapids OB GYN specialists

Thank you for choosing Cedar Rapids OB Gyn Specialists for your healthcare needs. We are committed to providing you with the best care possible. We feel it is important that you have a clear understanding of our financial policy as it is important to our professional relationship with you. Please carefully read and sign the following financial policy, a copy will be provided to you upon request.

Your Financial Responsibility

1. **Insurance Card:** You are responsible for bringing in a current insurance card to each appointment. We will copy this card for the proper filing of your claims, if you do not have a current card, you will be considered cash pay and full payment will be collected prior to your appointment.
2. **ID:** You may be asked to show a photo ID each visit/yearly, as an effort to prevent identity theft.
3. **Benefits:** You are responsible for knowing your policy and its limitations, such as copays, deductibles, exclusions and any policy restrictions. We do check the benefits for some procedures performed here at our office, you will be notified of what you are estimated to owe. This estimate is not guarantee of payment from your insurance company.
4. **Restrictions:** If you are scheduled for a test and your insurance restricts where you go, it is your responsibility to alert the scheduling staff. We routinely submit all specimens to Weland Laboratory for pathological interpretation.
5. **Copays & Deductibles:** You are responsible for paying your copay and deductible at the time of service, this arrangement is part of your contract you signed with your insurance company.
6. **Balances:** You are responsible for any balance that is not paid by your insurance company; payment is due upon receipt of your statement. Any balance that remains unpaid in excess of 30 days will be sent to an account recovery company.
7. **Returned Checks:** You will be assessed a $25.00 charge each time a check is returned for non-sufficient funds.
8. **Cash Pay:** You will be responsible for paying for services prior to being seen if you do not have insurance or do not have current insurance information with you.
9. **Payment Options:** You are responsible for your account balance; and responsible for contacting our billing department if you are unable to pay your balance in full. We gladly accept cash, checks, Visa, MasterCard, Discover and Care Credit. We have guidelines we must follow but we do make every effort to work out payment arrangements upon request.
10. **Missed appointments:** You will be assessed a $75.00 fee for missed, canceled or rescheduled appointments with less than 24- hour notice. These charges will be your responsibility and billed directly to you. Calling our office at least 24 hours prior to your scheduled appointment will avoid these charges. Patients who no-call-no-show twice may be dismissed from our practice.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand the financial policy and agree to abide by its guidelines:

Name: _____ DOB: _____

Signature: _____ Date: _____