2212 Wilborn Avenue, South Boston, VA 24592

Phone: 434-572-8921 Fax: 434-575-1290

FEES, PAYMENT & BILLING POLICIES

Your medical insurance policy is a contract between you and the insurance carrier. Your coverage, the requirements for pre-authorization, deductibles, co-payments and co-insurance are all defined in your policy and their verification is your responsibility.

You are responsible for all charges from the date of service. As a courtesy, we will file all claims for our service with your insurance company. Make sure that all the information you provided is accurate and up-to-date. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance company.

We require all patients to sign a copy of our Patient Registration/Demographic Form that assigns insurance benefits to be paid directly to *Fuller-Roberts OB/GYN & Primary Care.* In the event your insurance company sends payment directly to you, it is your responsibility to sign the check over to *Fuller-Roberts OB/GYN & Primary Care.*

We **cannot** waive any co-payments, deductibles or coinsurance amounts defined as patient responsibility under the terms of our contract with these various plans. If your insurance plan requires a co-payment, such copayment is due at the time of service; otherwise, your appointment may have to be cancelled and rescheduled. For your convenience, we accept Cash, Visa, MasterCard, Discover, or personal checks.

Returned Checks - There is a fee (currently $35) for any checks returned by the bank.

Your balances are due within 30 days of when the bill is issued. Bills will be issued after the insurance carrier pays its portion of the bill.

Any outstanding balance that is 60 days overdue, a $15 Service Charge will be imposed to help cover the costs involved in continuously sending overdue bills. For any outstanding balance that is 90 days overdue, your account may be forwarded to a collections agency and be subject to a collection fee equivalent to 50% of the unpaid bill.

I acknowledge I have read, understood and received a copy of Fees, Payment & Billing policy.

Print Name: _____ D.O.B. _____S.S. # _____

Signature (Guarantor/ Responsible Party): _____ Date _____