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## Financial Policy

Thank you for choosing Lawrence OB/GYN as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policies.

Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

### **Please initial each line below:**

\_\_\_\_\_ **Co-pays/Co-Insurance/Deductibles** -The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, deductibles and past due balances are due at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express for your convenience. If a patient is a minor (18 years and younger) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian is responsible for any payment due at the time of service.

If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us of your financial need prior to your visit. Please ask to discuss arrangements with our billing department.

\_\_\_\_\_ **Annual Exams** – These visits are intended to be preventative in nature and typically include age-appropriate history, exams and counseling. These visits are not intended to be problem-focused. While we are happy to manage *additional* problems that exist at the time of an annual exam *if possible*, it may be appropriate to change the type of visit such that a co-payment would be required. This decision cannot be made until your visit has been completed *and may depend upon the nature of the problem and the amount of time required to adequately address it*.

\_\_\_\_\_ **Insurance Claim**- As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to those charges above the usual and customary allowance. If we are out of network, and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

\_\_\_\_\_ **Self-pay Accounts**- Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file

with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

\_\_\_\_\_ **Cancellation of Appointments-** Lawrence OB/GYN requires 24-hour notice of appointment cancellation so that we can offer the appointment to another patient who needs to be seen. There is a fee of \$25 for appointments that are missed and not previously cancelled.

\_\_\_\_\_ **Returned Checks-** The charge for a returned check is \$25 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

\_\_\_\_\_ **Outstanding Balance Policy-** A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the Practice.

\_\_\_\_\_ **Assignment of Benefits-** I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to Lawrence OB/GYN. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_ **Laboratory Fees-** Most laboratory charges, such as blood work, PAP and pathology tests, ordered through our office are billed directly to your insurance by Quest Diagnostics or LabCorp. If you receive a statement from one of these laboratories, we request that you contact them directly to resolve any billing questions.

### ***Financial Policy for Obstetric Care***

*Please be advised of Lawrence OB/GYN's policy concerning your pregnancy and insurance coverage. Unlike other types of services, prenatal care is billed globally and will be billed at the end of your pregnancy, after delivery. Prenatal care includes your routine office visits and delivery charges.*

*During your pregnancy, physicians may order additional studies, such as ultrasounds or non-stress tests. These services will be billed to your insurance at the time of the service, and are not included in the global prenatal care fee. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. You may be responsible for co-pays and/or additional fees for these services, which will be determined by your contract with your insurance company.*

*Please be aware of the cost of delivery. Some insurance companies apply part of the delivery charges as co-insurance and/or deductible. This balance is considered part of the total reimbursement to the doctor, and will be your responsibility.*

*This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.*

*It is your responsibility to inform our office of any changes in your insurance.*

***I have read and understand the above information and agree to comply with these financial policies.***

*Print Patient Name:* \_\_\_\_\_

*Date of Birth:* \_\_\_\_\_

*Patient Signature:* \_\_\_\_\_

*Today's Date:* \_\_\_\_\_