

FRISCO OBSTETRICS AND GYNECOLOGY, P.A.
OFFICE AND FINANCIAL POLICY

Welcome to Frisco Obstetrics and Gynecology. We want to thank you for choosing us as your healthcare provider. In an effort to provide the best care possible, we would like to take a moment and explain a few of our policies.

Updating Information

Please be sure we have the most current demographic and insurance information at all times. You will be asked to sign in with your name, address, phone number, and insurance name at each visit, as well as complete a new demographic sheet on a yearly basis. Filing claims with incorrect information delays processing and increases patient liability. Please note if you fail to give us updated insurance information at the time of your appointment, we will not be able to file your claim to the correct company after 30 days from the date of your visit.

Appointments

We understand that your time is valuable and we do our best at keeping the schedule running smoothly and on time. Out of respect for all patients we ask that you be on time for each appointment. Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule for a different day.

Should an emergency arise, we ask that you be patient as we do our best to handle the situation and return to seeing patients as scheduled. Unfortunately, it may be necessary for us to reschedule appointments unexpectedly, should this occur we will do our best to notify you as soon as possible and reschedule you at the next earliest time.

Should you need to cancel or reschedule an appointment, please contact the office as soon as possible; 24 hours notice is appreciated. Failure to notify the office prior to your scheduled appointment 3 times could result in you being dismissed from the practice. A \$25.00 no show fee may also be assessed. This fee is not payable by insurance and therefore will not be filed; the patient will be responsible for payment.

Preventive vs. Problem Visit

A preventive service, such as a well woman exam, is a service provided to screen for various illness and disease. A problem visit is one when the patient has a specific concern, symptom, or complaint.

Some insurance carriers only cover services for preventive visits, while others may only cover services for problem visits. We recommend that you contact your insurance carrier prior to each visit and inquire about the type of benefits you have. The more familiar you are with your benefits the less likely you will have unexpected financial responsibility. Payment is due at the time of service, according to your current insurance benefits, this could include copays, deductibles, and co-insurance amounts.

Medicare

We are always glad to see Medicare patients. In an effort to help avoid unexpected expenses we would like to explain a little about Medicare. One, Medicare only covers certain preventive services and applies frequency limitations to those services. Medicare will cover the collection of a pap smear and the breast and pelvic exam once every 24 months. If you choose to have these services more frequently, you will be responsible for payment. Keep in mind, whatever Medicare does not approve, then any supplemental insurance will not cover either. Secondly, Medicare never covers the office visit portion of an annual well woman exam; the patient will be billed for this charge. Third, we are required by federal law and Medicare guidelines to charge all patients the same amount; therefore if you are seen for an annual well woman exam we must charge for the office visit, as well as the collection of the pap smear and the breast and pelvic exam. Should you have concerns about payment for your services, please speak with our billing department prior to your visit.

Non-covered Services

A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full for all charges.

Insurance

We are contracted with multiple insurance companies. Some insurance companies have special programs that allow for better benefits for you as the patient. While our physicians may be contracted with the insurance company in general, they may not be a preferred provider under these special programs. We suggest you always verify with your insurance carrier to confirm there is nothing specific about your plan that would exclude our physicians.

Payment

Our office attempts to verify all patients' insurance benefits prior to their appointment. Any copay, deductible, or co-insurance is due at the time of service. We will give you the best estimate possible based off of your benefits quoted. Please keep in mind, sometimes benefits are misquoted by your insurance carrier; however we must collect based off their explanation. Once your insurance carrier has finalized your claim, we will make any necessary adjustments to your account.

Outstanding balances are due in full upon receipt of statement.

Claims Filing

We are obligated to file claims for you with all contracted insurance companies. We will be happy to file your claims to non-contracted companies with the exception of Tricare. Should you have Tricare insurance, please let us know and we will provide a copy of the charges associated with your visit so you may file a claim on your own.

Secondary insurance plans can be of great assistance in the payment process. We will file deductible and co-insurance amounts to any secondary insurance (except Tricare) you provide us; co-payments will not be filed to your secondary. Also, if you have multiple insurance carries, please make sure each carrier is aware of the other and you provide us with accurate information. An insurance carrier in the patients name is always primary; you may not choose which carrier to use as primary vs. secondary.

Insurance Billing and Payment

In an effort to reduce patient financial liability, it is sometimes necessary for our billing department to appeal claims. In doing so, it may also be necessary to involve other agencies such as the Texas Medical Association and/or the Texas Department of Insurance. By signing this policy, you agree to allow us to release certain demographical and medical information to these agencies in order to secure payment. Please be assured we will only release information that is absolutely necessary.

Referrals/Authorizations

Should your insurance company require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment. Please note some insurance carriers will not allow your OB/GYN to issue a referral, you may be required to go through your PCP.

Labs

When you have a pap smear, HPV test, biopsy, culture, or blood work done we will send the specimen to an outside lab. Our preferred lab choices are PathAdvantage for pap smears, HPV test and biopsies, and Clinical Pathology Laboratory for blood work and urine. All lab tests will be billed by the appropriate lab. We do our best to forward the most current insurance information we have on file with each specimen. Occasionally this information does not forward properly. Should you receive a bill from the lab due to incorrect information simply call the lab and provide your current insurance information.

Responsible Party/Minors

The patient will be considered as the responsible party for payment purposes. If the patient is under the age of 18 the parent/guardian authorizing care will be responsible for payment of services. If a patient is over 18, regardless of who holds the insurance policy, the patient will be responsible for payment of services.

Refunds

Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued only after all outstanding claims have been processed and there are no upcoming appointments within the next 6 months. This policy is designed to reduce administrative work associated with refunding money and subsequently billing for new balances. A patient with an account credit greater than an estimated amount due for a new service should not have additional monies collected, or only the difference between amount due and credit balance.

**The exception to this rule is maternity patients working on OB deposits.

Returned Payment

Payment is accepted in the form of cash, check, money order, or credit card. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is \$15.00.

Medical Records

All medical records must be requested in writing. One copy of a patients medical record will be furnished free of charge upon request, there will be a \$25.00 fee for each subsequent request/copy. We suggest if you are seeing multiple physicians or transferring care that you retain a copy of your records and make duplicates on your own.

I have read, understand, and agree to the information and policies set forth in this agreement. I further agree that a photocopy of this agreement or an electronic signature is as valid as an original.

Patient's Name (Print) _____

Signature _____ Date _____

Parent/Guardian Name (Print) _____

Signature _____ Date _____