Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Payment Policy and Agreement

____ 1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but don't have an up-to-date insurance card, payment will be required in full until we can verify your coverage. Knowing your insurance benefits is your responsibility. If you have a HSA/HRA (High Deductible) insurance plan, payment is required at time of service. Please contact your insurance company with any questions you may have regarding your coverage.

____ 2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud**.

____ 3. **Non-covered Services**. Please be aware that some services you receive may not be covered by your insurance carrier. You must pay for these services at the time of your visit.

____ 4. **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a scan of your driver's license and current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim or be asked to re-schedule.

____ 5. **Claims submission**. We will submit your claims and assist you in any way we can to help you get your claims paid. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware your claim balance is your responsibility whether or not the insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. **Please contact your insurance company to be sure your plan's requirements have been met and that all referral and prior authorizations are in place before seeking care**.

____ 6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes. If your insurance company does not pay your claim in 60 days, the balance will be automatically billed to you.

____ 7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless prior financial arrangements were made. If a balance remains unpaid, we may refer your account to a collection agency. If the account is turned over to a collection agency, finance charges of 1.5% per month (18% per year) will be added to invoices.

____ 8. **Discharged patients**. You may be discharged from this practice if you fail to fulfill your financial obligation. If this happens, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period the doctor will only see you on an emergency basis.

____ 9. **Laboratory Fees**. Fees for services (pap smear, culture or biopsy, bloodwork) performed by an outside laboratory are your responsibility. If you should have any questions regarding those fees, please call the telephone number directly on the invoice.

Our practice is committed to providing the best treatment to our patients. Our fees are set according to the usual and customary fees for our specialty and area.

Thank you for understanding our payment policy and agreement. If at any time you have any questions or concerns regarding your care, we are here for you.

I have read and understand the payment policy and agree to abide by its guidelines.

_____
Patient Name (Print)

_____ _____
Patient Signature or responsible party Date