Gulf Women's Center for Health & Surgery
Tammy L. Birbeck DO

Gulf Women's Center for Health & Surgery
OFFICE FINANCIAL POLICY

Thank you for choosing Gulf Women's Center for Health & Surgery as your health care provider. We are committed to providing you with quality and affordable health care. The last several years have been a time of profound change regarding health care reform. It has become necessary to implement the following policies. **PLEASE REVIEW THOROUGHLY AND SIGN THIS SHEET CONFIRMING THAT YOU UNDERSTAND AND READ THIS FORM IN ITS ENTIRITY.**

Insurance:
Knowing your insurance benefits Is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and financial obligation such as deductibles, copays, and co insurances. Services that are not covered or specified by your plan will be your financial responsibility. Our staff will confirm your insurance benefits and estimate share of cost when applicable. Policies that charge by percentage rate or deductible amount will be at our discretion and we will notify you of the estimate. Additional fees, if any, will be due immediately upon receipt of statement.

Co-Payments and Deductibles:
All co-payments and deductible amount must be paid at the time of service and will be collected upon check in. This arrangement is part of your contract with your insurance company and failure to pay can be considered breach of contract or fraud. Unpaid balances such as deductibles and copays could result in cancellation of your health care benefits. If an additional amount is due, we require full payment upon receipt of the Invoice. We do not accept partial payments or payment plans.

Physician Participation, Coverage and /or Coverage Changes, Proof of Identity and Proof of Health Insurance:
Although we accept most insurances, it is the patient's responsibility to confirm of our participation with your specific network. Please contact your insurance carrier directly and provide them with the name of the Physician, address and they will provide you with this information.
We must obtain a copy of your insurance card and picture Identification for our records. All patient Information forms are required to be completed with up to date information, prior to receiving medical care. Failure to do so would result in a cancellation of the appointment.

HMO or PPO Patients requiring a referral:
You are responsible for making sure your visits with our office are authorized by your primary care physician ((PCP) unless otherwise specified that an authorization is not required. The authorization must be obtained prior to your scheduled visit. It is the patient's responsibility to ensure that we have received the authorization required. If you are unsure if you need authorization, look in the back of your card or contact the customer phone number for confirmation.

Claims Submission and Your Responsibility:
As a courtesy we will submit your claims and assist you in any way we reasonably can to help get a claim paid. An explanation of benefits (EOB) will be sent by the insurance carrier for your review after the claim has been received. Any missing information that is requested must be sent by you for the claim to be processed.
Please be aware that the balance of your claim is your responsibility even if your insurance company fails to pay your claim, we allow 30 days from the date of billing for your Insurance payment. The health insurance benefit is a contract between you and your insurance company only. We are not party to your specific contract.

Outstanding Balances, Past Due Accounts and Explanation of Benefits:
If your account is 45 days past due, you will receive a final letter stating that you have 15 days to make full payment. Please be aware that we may send your account to a collection agency. You and your immediate family members will be discharged from this practice. In the event of discharge, you will be notified by certified mail that you have 30 days to find an alternative health care provider. During that period our physician will only be able to treat you on an emergency basis.

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you have any questions regarding your policy and financial responsibilities.

By signing below, you agree that you have read the form and agree to the terms of our policy.

_____ Date:_____
Responsible Party Signature

_____ Relationship to patient: ( ) Self ( )Guarantor ( ) Other: _____
Printed Name