OB GYN Associates
2769 Heartland Drive, Suite 201
Coralville, IA 52241

Account #:_____

Patient Acknowledgement and Consent

Welcome to OB GYN Associates of Iowa City and Coralville! We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware and understand our policies.

Patient Liability We encourage you to become familiar with your health insurance plan. Each carrier has specific guidelines regarding coverage and benefits. It is **your** responsibility to understand the guidelines set by your insurance carrier. If you have benefit or coverage questions, please contact your insurance company directly. As a courtesy to our patients, we verify benefits for certain procedures. **A quote of benefits is not a guarantee of benefits or payment.** Your claim will process according to your plan. If a discrepancy exists between the benefits quoted and final payment of the claim, the terms of your insurance plan will override. We recommend you also contact your insurance carrier to check benefits.

Insurance Information We require complete and accurate insurance information in order to bill your insurance. If accurate information is not given to OB GYN Associates, the patient will be responsible for any balance. In accordance with your insurance contract, payment is required at time of service.

Appointment No-Show/Cancellation When cancelling an appointment, we require advance notice of 24-hours. If the appointment is not cancelled 24-hours in advance or you do not show up for a scheduled appointment, after **three late cancels or no-shows**, you will be charged a $25.00 no-show/late cancellation fee. This fee is not billable to your insurance and you will be responsible for the balance due. We reserve the right to discharge patients from OB GYN Associates for habitual abuse of this policy.

Returned Checks The charge for a returned check is $25.00. This charge is not billable to your insurance and you will be responsible for the balance due.

Minors A parent or legal guardian must sign the Patient Acknowledgement and Consent form. The parent or legal guardian that accompanies the minor patient to the clinic will be responsible for any payment as outlined above. It is the responsibility of the parent or legal guardian to forward any bills to other responsible parties.

Self-Pay Patients (No Insurance) Payment is due in full prior to services being rendered. If you are unable to pay at the time of your visit, your appointment will be cancelled and rescheduled at a time when payment can be made.

Collections If we have not received a payment on your account after sending 3 statements and no effort is made to make alternative payment arrangements with OB GYN Associates, your account may be turned over to an outside collection agency. This balance must be paid in full in order to continue your care with OB GYN Associates.

I hereby authorize OB GYN Associates to release necessary medical information to my insurance carrier to process all claims and hereby assign to OB GYN Associates all payments for medical services rendered. I understand I am responsible for all amounts not covered by insurance. I further understand that copays and coinsurance are due at the time of service.

I have been offered a copy of the Notice of the Privacy Practices of OB GYN Associates. OB GYN Associates reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices.

I understand OB GYN Associates uses electronic prescribing. My prescriptions will be sent and my medication information may be obtained through OB GYN Associates electronic prescribing functionality.

I understand OB GYN Associates will report any vaccines administered throughout my care to IRIS (Immunization Registry Information System).

Patient Signature:_____Date:_____
(Legal Guardian/Patient Representative - required if patient is minor or adult unable to sign)
Legal Guardian Address: _____

_____

Relationship to Patient: _____