4239 Farnam St. Suite 734 / (402) 552-2700
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 552-2700
Medical Record Fax / (402) 552-2972
Office Fax / (402) 552-2709

FINANCIAL POLICY OF
OMAHA OB/GYN ASSOCIATES, P.C.

Thank you for choosing Omaha OB/GYN Associates, P.C. The following is a statement of our Financial Policy. All patients must accept our Financial Policy before receiving treatment. Please understand that full payment of your bill is considered a part of your treatment.

METHOD OF PAYMENT: We accept cash, checks, and all major credit/debit cards. A payment plan may be arranged on individual basis with the Financial Consultant in our office.

REGARDING YOUR INSURANCE: 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. We cannot bill your insurance company unless you give us your complete insurance information. Without complete insurance information you will be considered Self-Pay. It is your responsibility to know your insurance benefits; it may not cover all of the services provided to you.

DEFINITIONS

COPAYMENTS: A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit. This amount is usually between $10.00- $60.00.

DEDUCTIBLE: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation and must be paid prior to health care services.

CO-INSURANCE: A percent set by your insurance plan that is deducted from insurance benefits. This percent usually ranges between 10% and 30% and is your obligation to pay.

REGARDING INSURANCE PLANS where we are a participating provider: **All co-pays are due PRIOR to treatment**.

SELF-PAY PATIENTS: Require $100.00 down payment PRIOR to treatment. You may receive a 25% discount if Paid in Full the day of the appointment, with the understanding that charges may be pending from the lab or physician's dictation other wised mentioned at the time of payment.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

Signature implies receipt and understanding of our financial policy.

_____	_____	_____
Patient or Responsible Party	**Responsible Party Relationship to Patient**	**Date**

For Practice Use Only:
Patient Name (Print) _____Acct. #_____