Redlands Obstetrics and Gynecology Associates
Samir E. Hage, D.O., Inc.
255 Terracina Boulevard, Suite 202
Redlands, CA 92373
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Patient Financial Responsibility Acknowledgement

We would like to thank you for choosing Redlands OB/GYN Associates, Samir E. Hage, D.O., Inc. as your medical provider. As one of our patients we would like to keep you informed of our current office and financial policies. We require a signature prior to treatment. Please keep the copy provided for future reference.

Payment Methods: We accept Visa, MasterCard, check, or cash. There will be a 3% credit card fee for each transaction. In an attempt to reduce cost overhead we ask that payment be made at the time of service or in receipt of your statement after insurance has paid. Pursuing payment after we provide a service increases healthcare cost.
Insurance Claims: As a courtesy, we will file medical claims to your insurance company. Therefore, it is necessary to present ALL current insurance cards at the time of your appointment. We must be notified immediately of any changes; incorrect information delays payment and you will be responsible. As the insured, your coverage is based on the contract between you and your insurance carrier. In some cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowances. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. You must contact your health plan if you have not received notice of payment within 30 to 45 days of your service. Keep in touch; do not assume that they are "working on it."
Patient Financial Responsibility: Your insurance dictates that we collect co-payments, deductibles and coinsurance, which is not subject to discounts or adjustments. Appropriate adjustments will be made to your account should we hold a contract with your insurance company. You may also be responsible for 1) denied claims, 2) partial payments such as the health plan's arbitrary determination of "usual and customary" rates, 3) and non-covered services.
Co-payments & unsatisfied deductibles: Co-insurance payments are due at every appointment. Prenatal care co-insurance payments for complete pregnancy and delivery care are due and payable in full per contract provided at first or second visit. If you are unable to pay it in full, our billing department will be glad to set up a payment plan which will allow you to make payments at each visit. Prenatal care contracts must be paid in full by the 32nd week of pregnancy.
Uninsured: For uninsured patients, 100% payment is required at the time of your first appointment. Total charges cannot be determined until you have been examined; however, in addition to the office visit, there are additional costs associated with procedures. Our billing department is available to assist you in making arrangements for your office visit(s). We offer a discount for payment in full at the time of service; however, if you unable to pay the balance in full, our billing department will be glad to enter into an ob contract which will allow you to make payments at each visit and must be paid in full prior to the 32nd week of pregnancy.
Referrals: Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient/parent/legal guardian to obtain any referral, and updates, required by the health plan. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.
Delinquent Accounts: All accounts must be satisfied within 60 days unless arrangements have been made with our billing department. A prior arrangement for a regular scheduled payment plan is required; a partial payment for money due is unacceptable. We may reschedule appointments or discontinue our relationship with you should bills go unpaid and no attempt has been made to reconcile the account. Interest may be charged at the rate of 7% for accounts that are delinquent in excess of 60 days.
Collection Accounts: If your account is referred to a third party for handling service charge may be applied to your original balance.
NSF FEE: There is a $35.00 service charge for any returned check.
Supplemental Income/Disability Insurance Forms: There will be a charge of $35.00 for the completion of insurance disability forms. Payment is due at the time of drop off. Please allow 5-7 business days for processing.
Minors: Minors under the age of 18 must be accompanied by a parent or court-appointed legal guardian for treatment. The accompanying parent or adult is responsible for payment. In divorce situations, please do not place our office in the middle of marital disputes. It is the responsibility between the custodial and non-custodial parent to work out payment arrangements of the child's medical care.
Our billing department is available to answer any questions that you might have regarding billing or estimates

I have read and agree to the terms of the policy and have received a copy of the Patient Financial Responsibility Acknowledgement. I hereby assign all medical and/or surgical benefits from _____ to Samir E. Hage, D.O., Inc., Redlands OB/GYN Associates.
Name of insurance company

_____ _____
Signature of Responsible Party Relationship to patient

_____ _____
Print Name of Responsible Party Date

MEDICARE PATIENTS: We submit and accept assignment on all Medicare claims. As a courtesy, we will file to your secondary insurance. I reque that payment of authorized Medicare benefits be made either to me or on my behalf to Samir E. Hage, D.O., Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

Signed _____ Date_____