FINANCIAL POLICY

I authorize payment of medical benefits to Reiter & Hill, PLLC dba Reiter, Hill, Johnson & Nevin (RHJN) for all services provided.

I understand that from time to time RHJN will verify my insurance coverage as a courtesy to me. I also understand that coverage amounts and out of pocket expenses change based upon claims that are processed and changes in coverage. I further understand that it is ultimately my responsibility to verify payment and coverage amounts with my insurance provider. In all instances, I acknowledge full financial responsibility for any financial balance resulting from my care at RHJN.

I acknowledge that any charge for a cord blood collection, lab stat fee, diaphragm, meet and greet appointment, and FMLA form completion may be submitted to my insurance company and if denied for any reason I will be billed directly by RHJN.

I will receive a statement for any balance remaining after insurance processing. Any such remaining balance is to be paid within thirty (30) days of receipt of a statement. If I fail to pay in a timely manner, I understand that my account could be referred to a collection agency resulting in my discharge as a patient from RHJN. In the event I am referred to a collection agency, I acknowledge that I will be financially responsible for any collection fees incurred. Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency may be subject to a collection fee of 33%, which will be added to the total balance due at the time of the transfer to the outside collection agency. If my account is referred to collections, I understand that I will be allowed to return to RHJN as a patient only after my balance is paid in full (including all fees incurred) and I will pay a $250.00 deposit that will be held until all charges for my current visit are paid in full. If a credit exists after the services have been paid, the balance of the $250.00 will be refunded to me. I understand that under no circumstances will I be allowed to return to RHJN as a patient if I am referred to collections a second time.

I understand that it is my responsibility to provide RHJN with my current mailing address, telephone number(s) and insurance card(s) at the time services are rendered to me. If I cannot provide a copy of my current insurance card, I understand that my appointment could be rescheduled at RHJN discretion. I also understand that if I provide incorrect or expired insurance information I assume full financial responsibility for all charges incurred.

I confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to misinformation. I authorize the release of any medical or other information to process the insurance claim. I authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her service as described, realizing that I am responsible to pay non-covered services.

I understand that if I do not have health insurance, I will be considered a cash payment patient and will be offered a 20% discount off the published practice fee for each service rendered.

I understand that I will be charged a $50.00 no show fee if I do not call to cancel/reschedule my appointment at least 24 hours before my scheduled appointment time with any provider or sonographer. This amount must be paid prior to any future visit with RHJN.

I understand that I will be charged $20.00 to call in any prescription that is lost.

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Signature of Patient or Legal Guardian

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Printed Name Date