



## FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept checks, cash, MasterCard, Visa and Discover credit cards and ATM debit cards.

### YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have contracted with and will only require you to pay the authorized copayment at the time of service. It is the policy of our office to collect the copayment and unmet deductible if applicable when you arrive for your appointment.

If you have insurance coverage with a plan that we do not contract with we will prepare and send the claim for you on an assigned basis. This means your insurer will send the payment directly to our office. Any unmet deductibles and/or balances remaining after your insurance has paid is your financial responsibility. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

### MINOR PATIENTS

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of Perinatal Associates of New Mexico, Ltd. and I agree to be bound by its terms. I agree that should I fail to pay any amount due by myself, I will be responsible for any collection and/or attorney fees. I also understand and agree that such terms may be amended from time-to-time by the practice.

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Signature of Patient or Responsible Party if a Minor

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Date

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Signature of Co-Responsible Party