

Greater Washington Maternal-Fetal Medicine and Genetics



POLICY PAYMENT OF MEDICAL SERVICES

Our first priority is to provide you with optimal medical care and the finest customer service. In order to maximize customer relations between you and Greater Washington Maternal Fetal Medicine and Genetics, it is important that you be aware of our business policies.

You must provide us with current , valid, and accurate information regarding insurance policy. You must inform us immediately when that coverage changes. You are financially responsible for payment for all services rendered if the information given is incorrect, or if you are not covered. Our practice participates with many insurance plans.

Because individual policies vary so widely, insurers do not inform us of their terms. Therefore, we cannot guarantee that your insurance company will pay all services provided. If you are concerned about the coverage of a particular procedure, contact your plan's member services department to obtain that information. If you have Maryland Medical Assistance, a MCO, or a HMO and you have not obtained the necessary preauthorization or if you are receiving a service that is not authorized by the Medical Assistance Program or your HMOs plan you will be billed for these services.

It is the patient's responsibility to know when a referral/authorization is needed, and to bring a valid paper referral or referral/authorization number at the time that services are rendered. If you do not know if your plan requires a referral, please contact your health plan. Please also advise them that this is a specialist practice and not an obstetric one. Most managed care plans, especially HMO and POS, require a referral to a specialist from the primary care physician. If you fail to bring one, you will be financially responsible for payment. If you are eligible for Maryland Medical Assistance or a MCO and you are being seen with out the necessary preauthorization/referral, you are knowingly choosing to be served by our providers and you will be responsible for all charges and payments. If you have Blue Choice HMO/Open Access, a referral is required for all sonograms and procedures. If you do have out-of-network benefits, and fail to bring us a referral for services, your signature on this form indicates that you will allow us to charge and receive payment from the out-of-network portion of your policy. All co-payment must be paid at the time of service.

All outstanding account balances must be paid in full with in 60 days to avoid a late fee of \$5.00 per month. All accounts remaining unpaid after 120 days may be submitted to our debt collections attorney unless you make payment arrangements. You will be held responsible for all collection costs and attorney fees. A fee of \$35.00 will be assessed on all returned checks.

Your signature below indicates that you have read and understood this notice, and that you agree to its contents.

Signature of patient or responsible party

Date