Simi Obstetrics & Gynecology Medical Group
A Medical Corporation

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Simi Obstetrics & Gynecology Medical Group** as your healthcare provider. We are committed to delivering the highest quality of care. Please read and sign this form to acknowledge that you understand and agree to our patient financial policies.

INSURANCE CIAIMS

As a courtesy, we will file an insurance claim for you. However, if your insurance company denies payment for any reason, you or the guarantor will be responsible for any balance due. It is also your responsibility to provide a current address, billing information and insurance information by carrying an updated insurance card. It is also your responsibility to promptly follow up with any requests from your insurance company for additional information.

❑ I understand. Initials : _____

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.

❑ I understand. Initials : _____

CO-PAYMENTS, DEDUCTIBLES and BALANCES

- Co-payment is due at the time of your visit.
- Deductibles are a patient's responsibility. The deductible is determined by the contract you have with your insurance carrier.
- Balances are due within 30 days of receiving a statement or at or next scheduled visit – whichever occurs first.
- If you have no insurance, you will be required to pay 100% of the visit charges at the time of your visit.

❑ I understand. Initials : _____

NON-COVERED SERVICE

You or the guarantor is responsible for "non-covered" services if denied by their insurance carrier.

❑ I understand. Initials : _____

COLLECTION ACCOUNTS

- In the case your account is forwarded to a collection agency, you are responsible for paying the collection fee as well as a processing fee.
- A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

❑ I understand. Initials : _____

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(805) 527-8055 • Fax (805) 520-8849

MISCELLANEOUS FEES (subject to change without notice)

- **$15 Form Fee**: Per set of forms that are requested to be completed by this office
- **$25 Letter Fee**: Per letter draft fee for letters requested by patients
- **$50 No-Show Fee**: Same Day cancellation/reschedule appointments or no show
- **$10.75 Collection Fee**: If your account is sent to collections for non-payment
- **$6** Collection Processing Fee: Preparing your account for collection agency
- **$35 NSF Fee** per returned check. You will be required to pay the original amount in addition to the $35.00 NSF fee before being seen for another appointment.

❑ I understand. Initials : _____

MEDICARE//MEDI-CAL PATIENTS ONLY:

We are not contracted with Medi-Cal, but we will bill them as a courtesy. After Medicare and Medi-Cal have processed the claim, any remaining balance is the patient's responsibility.

❑ I understand. Initials : _____

As your medical care provider, our relationship is with you - not your insurance company. It is your responsibility to understand the details of your insurance policy and coverage. We sincerely thank you for choosing **Simi Obstetrics & Gynecology Medical Group** as your healthcare provider. We are here to support you and are happy to assist with any questions you may have.

By signing below, you agree:

- **You have read, understand and agree to the above information.**
- **You understand that you are responsible for familiarizing yourself with all aspects of your health benefits.**
- **You understand that you are responsible for charges that are not covered by your health benefits.**
- **You understand that Simi OB/GYN or any company acting on their behalf, may use various dialing and communication methods to reach you at the telephone number(s) you have provided. This includes but is not limited to dialing or texting your wireless telephone number, which could result in charges by your wireless carrier, either manually or using automatic dialing technology and/or prerecorded messages.**

Signed: _____ Date: _____

Print Name: _____ Mobile Number: _____

If not signed by patient, please indicate the relationship:

- ☐ Parent / guardian of minor patient
- ☐ Guardian / conservator of an incompetent patient
- ☐ Specify Other: _____

Name of Patient: _____ Date of Birth: _____