SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.
PATIENT FINANCIAL POLICY .
TAX ID 95~4282339

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. The following is a statement of our Financial Policy . In order to reduce confusion and misunderstanding between our patients and practice we-require you read and sign this statement prior to any treatment. If you have any questions regarding these policies, please discuss them with our front office staff or supervisor.

- We have made prior arrangements with many health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay ·the authorized co-payment, deductibles and/or coinsurance at the time of service. It is our policy to collect the co-payment at the time of service .

- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

- In the event that your health plan determines a service to be "not covered", "not medically necessary" or "not authorized", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company directly.

- Your insurance policy is a contract between you and your insurance company, our group is not involved.

- HMO's and some other insurance require an official referral and/or authorization form. If we have not received it in our office at the time of service, you will be required to sign a Waiver of Responsibility Form and a deposit of payment may be expected.

- If you have pending Medi-Cal coverage, we require a $75.00 deposit at the time of service. If you provide a retroactive Medi-Cal card that covers your service date, we will refund your deposit.

- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule your appointment. There is a cancellation fee if you do not cancel or reschedule your appointment without prior 48 hour advance notice.

Additional services such as laboratory and genetic counseling are an additional charge and you will be billed separately.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

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Signature of Person Financially Responsible Date

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Please Print Name of Patient