MERCED OBGYN CARE, INC.
KRISTINA SOGOCIO, M.D.
360 E. Yosemite Avenue, Suite 300 · Merced, California 95340
Telephone: (209)723-6624 Fax: 877-682-6602

FINANCIAL POLICY AGREEMENT

Please initial all: Date: _____

_____ **Account Balances:** Full or partial payments due at check-in for all patient accounts.

_____ **Bounced/Returned Check Fee:** All returned checks will incur a **$25.00** administrative fee billed to the patient's account.

_____ **Cancellation and No Show Policy:** If it is necessary to cancel your scheduled appointment, we request that you call 24 hours in advance. A failure to cancel or present at the time of a scheduled appointment will be recorded in your chart as a "no show" and an administrative fee of **$50.00** will be billed to your account. Patients with 3 "no shows" will be dismissed from the practice.

_____ **Collections Policy:** All outstanding patient account balances greater than $50.00 will be sent to a third-party collections agency for payments not received within 60 days of services performed. Patient further agrees to pay all finance charges, collections costs (40%), Attorney fees, and any other cost that may be incurred to enforce collection of any amount.

_____ **Co-payments/Co-Insurance:** Due at time of services rendered; exact amount of cash is appreciated, as office carries minimal cash for change. Checks and credit cards (Visa, MasterCard, and American Express) are accepted. Services that are not covered under a preventative Well Woman Exam (Annual) that are discussed at the time of the visit may incur an additional office charge, which could result in a copay at the time of the visit.

_____ **Finance Charges:** As of **January 1, 2015**, any patient account with a balance of $50.00 or greater will be assessed a finance charge of 2% for payments not received within 30 days of services performed. An additional finance charge of 2% will be assessed every 30 days that full payment is not received.

_____ **Insurance:** Your insurance policy is a contract between you and the insurance carrier; the Physician is not involved in this contract. You are contractually responsible for your co-payment, co-insurance, or any balance unpaid at the time of service. The office no longer accepts *new* patients with Medi-Cal or Central Coast Alliance. *Existing* patients who switch to these carriers will be given 90 days to find a new provider or establish themselves as a self-pay patient.

_____ **No Insurance:** Patients who are self-pay are responsible for the entire balance at the time of service.

_____ **Payment Plans:** Any patient with an account balance greater than $50 may set up a payment plan with our office with a finance charge of 2% added. At minimum, 10% of the total balance must be collected each month.

_____ **Payment Methods:** Merced ObGyn Care, Inc. offers several payment methods to help accommodate a patient's financial status. Patients can choose:

- Provide a credit card for the staff to keep on file, and any account balance will be charged to the card on file monthly at a date of the patient's choosing;
- Receive monthly statements in the mail and pay the full balance promptly;
- Set up a payment plan with our office. Once established, the patient agrees to adhere to the chosen payment method until her balance is paid in full.

_____ **Secondary Insurance:** Patients who have a secondary insurance and do not present their secondary insurance card at the time of their appointment will be responsible for any balance remaining on their account after the primary insurance has paid.

FINANCIAL POLICY CONSENT

Please select preferred account payment method (CHOOSE ONE):

☐ I authorize Merced ObGyn Care, Inc. to charge my credit card for account balances under $250 without notice. No statement will be provided. Merced ObGyn Care, Inc. will send a detailed receipt within 5 business days of the transaction. If the charge is not accepted by the credit card company a monthly statement as described below will be sent and this selection will be voided until a valid credit card is received.

Visa, MasterCard, American Express (Please circle one)
Card Number: _____ Exp. Date: _____ CVV Code: _____
Card Holder Name: _____
Card Holder Signature: _____

☐ I prefer to receive a monthly statement in the mail and I agree to pay promptly. I understand that by selecting this choice a $20.00 service fee will be applied if an additional statement is needed to be mailed.

☐ I have an HSA account that should automatically pay my account balance. I understand that by selecting this choice I will be billed monthly, will promptly pay my balance not paid by my HSA account, and that a $20.00 service fee will be applied if an additional statement is needed to be mailed.

I have read and agree to the Financial Policy of Merced ObGyn Care, Inc.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Thank you for your cooperation!