Patient Name (print): _____ Date of Birth: _____

KALISPELL OB / GYN, PLLC

(Initial)_____ **FINANCIAL RESPONSIBILITY**:

1. I understand that I am ultimately responsible for payment of my account and that payment of co-pays and pre-payments is expected at the time of service.
2. I understand that I am responsible for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles.
3. Kalispell OB/GYN will file insurance claims for all companies, including but not limited to Medicare, Medicaid and Tricare. I hereby authorize payment of medical benefits to Kalispell Obstetrics & Gynecology PLLC for services rendered to myself.
4. I understand and acknowledge that fees charged are for the Provider and services completed by Kalispell OB/GYN only. Any Labs, Pathology, and related services performed at Kalispell OB/GYN will be sent for examination and billed separately by a different vendor. **I understand it is my responsibility to ask about any test <u>prior</u> to the test being done if I am concerned about cost.**
5. *<u>I understand and accept that if I make payment with a check and that check is dishonored or returned for any reason, I will be assessed an additional fee of $25 to my account.</u>*
6. *<u>I understand that if I do not pay all of the charges due from me, my past due account may be turned over to an outside collection agency.</u>*
7. I authorize **Kalispell OB/GYN** and any third-party collection agents to use all contact information I have provided.

(Initial)_____ **INSURANCE COVERAGE**: I understand that I am responsible for providing **Kalispell OB/GYN** with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information.

(Initial)_____ **LABORATORY FEES:** I understand that **Kalispell OB/GYN** cannot guarantee that my insurance will cover any lab/pathology performed by or ordered by my physician. If my insurance requires use of a *<u>specific lab</u>*, I understand it is my responsibility to inform my physician/ nurse *<u>BEFORE lab/pathology is performed</u>* for proper handling.

(Initial)_____ **PRESCRIPTIONS:** I understand that **Kalispell OB/GYN** uses electronic prescribing. My prescriptions will be sent and my medication information may be obtained through our electronic prescribing function.

(Initial)_____ **RELEASE OF INFORMATION:** I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to other physicians for my ongoing care or as required by my insurance company.

(Initial)_____ **NOTICE OF PRIVACY PRACTICES:** I acknowledge receipt of the Notice of Privacy Practices that describes how **Kalispell OB/GYN** may disclose and use my protected health information.

(Initial)_____ **LAB AND PATHOLOGY RESULTS:** I understand that any labs or pathology that is completed at my appointment will have results that need to be reviewed. I understand that if **Kalispell OB/GYN** has not contacted me within 2 weeks with those results, it is my responsibility to call **Kalispell OB/GYN** to confirm and review the results.

Signed: X_____Date: _____

If signed by patient's personal representative, please indicate:

Print name: _____ Relationship to patient: _____