FOXHALL OB/GYN ASSOCIATES

Patient Name: _____ Patient Account No.: _____

Patient Financial Agreement and Authorization to Release Information
For Treatment, Payment and Operations

I, the undersigned, realize that I am financially responsible for all services rendered to me by Foxhall OB/GYN Associates, PC (The Practice).

For those insurance plans that The Practice accepts assignment, I realize that I am financially responsible for co-payments, deductibles and non-covered services ad dictated by my insurance plan.

If the practice does not participate with my insurance plan, I realize that I am financially responsible for the payment of all healthcare services at the time they are rendered.

Foxhall OB/GYN Associates does NOT participate in the Blue Choice HMO network and any other HMO plans.

I authorize payment to be remitted directly to Foxhall OB/GYN Associates for which The Practice accepts assignment.

I authorize Foxhall OB/GYN Associates to release to my insurance plan(s) any medical information necessary to obtain reimbursement, including mental health and substance abuse information. Without expressed revocation, this consent is valid for one (1) year.

If payment for services is not received, Foxhall OB/GYN Associates, PC will forward your account to a collection agency. If a collection action is instituted, 30% collection agency fees and legal fees will be applied to your account.

We require 24 hours notice to cancel an appointment. Failure to do so will result in a no show/late cancellation fee being applied to your account. This fee will not be billed to your insurance company and you will be held financially responsible for paying this fee.

If you fail to pay your co-payment or any balance due on your account at the time of service, a $10 billing fee will be added to your account. This fee is not reimbursable under your insurance plan, so you will be held financially responsible.

I permit a copy of this authorization to be used in place of the original Circle One

Yes/ No

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Date

Yes/ No

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Date

Yes/ No

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Date

Yes/ No

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Date

Yes/ No

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Date