**HIGH RISK OBSTETRICAL CONSULTANTS**
**PAYMENT POLICIES AGREEMENT AND CONSENT FORM**

As a patient of High Risk Obstetrical Consultants, PLLC ("HROC"), I accept the terms of HROC's Payment Policies (as amended from time to time). I further acknowledge, agree and consent as follows:

_____ (Initial) Payment is due and expected in full at the time services are rendered unless other arrangements have been made PRIOR to this appointment. This includes deductibles, co-payments, co-insurance and non-covered charges.

_____ (Initial) My insurance will be filed, as a courtesy, and that I am responsible for any and all balances not covered by my insurance plan. I also understand that all insurance cards, both primary and secondary, must be given at the time services are rendered. If insurance cards are not given at the time of the initial visit, then the practice has no obligation to file claims on my behalf. If cards are not given then any filing with insurance will be my responsibility.

_____ (Initial) My insurance may disallow charges as above "reasonable and customary" and that these amounts are my responsibility and NOT a contractual write-off.

_____ (Initial) I am fully responsible for any referrals or prior authorizations required by my insurance company for payment to be made on my claims. If these are not obtained and payment for services is denied from my insurance carrier, all balances will be my responsibility.

_____ (Initial) I understand that I will be responsible for any attorney's fees, court costs, and/or collection fees added to this account if it becomes necessary to refer my account to outside collections.

_____ (Initial) Any patient whose check is returned to HROC and marked "NSF" (non-sufficient funds) or "Account Closed" will be charged an additional $35.00 for administrative fees in addition to the amount on the check.

_____ (Initial) Subject to applicable law, I authorize HROC to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care **(including, without limitation, any substance use disorder records)**. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services.

_____ (Initial) **HROC may disclose any information necessary for payment and health care operations purposes (including, as applicable, any substance use disorder records).** I understand that, to the extent such information contains substance use disorder records, HROC will provide a list of entities to which my information has been disclosed upon my request. I may revoke my consent to HROC to disclose substance use disorder records for payment and health care operations purposes at any time (except to the extent HROC has already relied upon my consent, including disclosure to a third-party payor). Unless revoked by me, my consent to HROC to disclose substance use disorder records for payment and health care operations will expire after the payment of all claims related to my care and treatment.

_____ (Initial) To help us file prompt and accurate claims, I have provided a list all of my insurance coverage, including policies covered by spouse, partner, parent, Medicaid, Medicare or legal guardian. (**Note: You are required to reveal ALL primary, secondary and tertiary insurance at the time of service. You may be held responsible for claims that are denied as a result of incomplete insurance disclosure.)**

I have carefully read, agree to and understand the above. I permit a copy of this agreement/consent form to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

_______________________________________________ ________________

PATIENT'S SIGNATURE DATE

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PATIENT'S NAME (PLEASE PRINT)