Courtview OB/GYN
Financial Policy

Thank you for choosing Courtview OB/GYN as your healthcare provider.

The following is a statement of our Financial Policy. We ask that you read, acknowledge, and understand this policy. If you have any questions or concerns about this policy please do not hesitate to ask.

After a patient misses three appointments without cancellation, her account will be charged $30.00. Patients who repeatedly miss appointments may be dismissed from the practice.

Parents/Guarantors are expected to pay any deductible, co-insurance, or co-payment when they arrive for the appointment. We ask that you verify this information, prior authorization, and/or other important information with your insurance carrier before you arrive. Patients with no insurance are expected to pay $100.00 or the amount of the visit, whichever is less.

Regardless of insurance status, the patient/guarantor is ultimately responsible for the payment of services.

If you have insurance we will make every effort to obtain reimbursement from that source. However, you will be responsible for any deductibles, co-insurance payments, or co-payments. In the event we are unable to collect from your insurance, we will look to you for payment.

You will begin receiving monthly statements as soon as your account has a patient balance. We encourage you to pay the entire balance as soon as possible. If you need to make payment arrangements, please call our Billing Department at (704) 854-3600.

Once a patient account is over 90 days old, with no payment activity or attempts to contact the Billing Department, you will be sent a 30 day notice. This notice will give you 30 days to pay in full or set up a payment plan. If at the end of 30 days you have not made payment or arrangements the account will be turned over to a Collection Agency.

Again, thank you for choosing Courtview OB/GYN. We appreciate the opportunity to give you quality medical care.

I have read and fully understand this Financial Policy. I agree to pay for all balances in my patient account. If I have insurance, I understand that I am responsible for following my insurance plan's regulations, policies, and procedures.

Signature of Patient or Guarantor

____________________________________ Date ____________________________