4507 Hospital Street
Pascagoula, MS 39581-5336
228-769-1940 228-769-8132
FAX 228-769-9231
www.gcobgynms.com

Gulf Coast OBGYN

Dr. Julius Bosco, Jr.
Dr. Nestor Delgado
Dr. Holly Summerlin
Dr. Taylor Banahan
Dr. Fang Weng
Meagan Heidelberg, WHNP

Financial Responsibility Agreement and Consent for Treatment

Name of Patient _____ Record # _____

- This is to certify that the undersigned authorizes the examination, operation, or treatment as may be necessary or advisable by Gulf Coast OB/GYN, P.A.

- The undersigned, as the patient or as her authorized representative, do hereby authorize Gulf Coast OB/GYN, P.A., to release to my insurance company (ies) or other appropriate agency (ies) that information which is necessary to validate these claims or verify employment for validation of insurance. Gulf Coast OB/GYN, P.A. is also hereby authorized to release to any other physician (s) either as individuals or as a professional association, who performs services to me, such information as is necessary for billing purposes.

- I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Gulf Coast OB/GYN, P.A. I also understand that my insurance may not pay for my total charges due to deductible, co-insurance, or non-covered services (i.e. thin prep, hematocrit, hemocult, Depo Provera, IUD, etc.) of which I will be financially responsible for. A copy of this can be considered as an original for insurance purposes.

- I acknowledge and understand that I am responsible for all of the charges and services that are rendered to me or any member of my family. Although I have requested the doctors to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that my bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangement for the prompt payment of this bill.

- If this bill is not paid within the ninety (90) day period from demand or billing, Gulf Coast OB/GYN, P.A. may turn the collection of this account over to a collection agency or attorney. I agree to pay 45% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

- I understand if I have a balance given to a collection agency, I may not be able to get an appointment, get a prescription and/or medication samples until the balance is paid in full.

- An overpayment of more than $100 will automatically be refunded and a check mailed to your last known address, unless otherwise specified by you, the patient/responsible party. An overpayment of less than $100 will automatically be credited to your account, unless otherwise specified.

- I have read this agreement and understand its contents. I recognize that as of today's date I renew my obligation to any previously incurred debt with Gulf Coast OB/GYN, P.A.

- I hereby authorize Gulf Coast OB/GYN. P.A. to obtain employment verification from my employer.

_____ _____
Signature of patient (or responsible party if patient is a minor) Date

_____ _____
Patient's Social Security Number Responsible Party's Social Security Number, (if patient is a minor)

_____
Employee Witness Signature