



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 minor 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