

## **OBGYN of Lancaster**

### **Summary of Patient Financial Policies**

The physicians, midwives, nurse practitioner and staff of OBGYN of Lancaster value the trust and responsibility you place in us to care for you. **Thank you** for choosing OBGYN of Lancaster. We are proud of our history of serving women through the stages of life since 1947, and we hope to have lifelong relationships with each of our patients. We hope this brief summary of OGL's patient financial policies can provide information and support open communication. Our Central Business Office staff is available at 717-519-1550 if you have questions.

**OBGYN of Lancaster is part of Lancaster Medical Group, LLC:** We share a common electronic medical record for patient safety and high quality care. We share a Central Business Office and professional support staff to keep our health care cost as low as possible. The statements for patient balances (what you owe after insurance and discounts) are titled Lancaster Medical Group LLC and payment is mailed to a lock box at our bank in Atlanta Georgia. They provide secure, confidential and cost efficient financial processing.

**Fees:** Our fees for professional services are consistent with those in the community. An estimate of OGL's fees for proposed services may be obtained upon request, and is routinely provided for maternity patients and when scheduling surgeries. OGL's fees do not include hospital charges, lab charges or other specialty physician charges such as anesthesiologists, pathologists and radiologists. We will arrange a hospital representative to contact you to review hospital charges upon request, or you may contact the hospital directly at 717-625-5518.

**Registration and Financial Information:** To process claims on your behalf, we must have your complete insurance coverage(s) information, your employment, and your guarantor (another individual responsible). Bring your drivers license or other picture ID to your first visit. **Bring your current insurance card with you for every visit.** We will update and/or confirm the accuracy of this information at each office visit. It is your responsibility to inform us in a timely manner of any changes to your billing information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. If your insurance requires a **referral form or authorization**, it is your responsibility to obtain this from your primary care provider prior to your appointment.

**Payment at the Time of Service:** Please be prepared to pay the patient portion of your visit, any co-payments and non-covered services at the time of each visit. We will also collect all previous outstanding patient balances during check out at the end of your visit.

**Credit Cards:** As a convenience, OGL accepts Visa, MasterCard and Discover credit cards plus debit cards. We offer the option to pay the balances of charges due after insurance payments on your credit card. You may call the Central Business Office directly when you receive your statement.

**Self Pay:** For patients who do not have insurance, we offer a prompt pay discount of 20% if charges are paid in full at the time of service. If you are unable to pay in full at the time of service, you must pay the greater of 20% or \$50 at the time of service and agree to pay the balance in a budget plan. If unable to do so, you must complete a "Financial Responsibility Agreement". The prompt pay discount does not apply to products (eg. an IUD or injectable drugs).

**Prepaid planning:** Patients who are preparing for a birth or planning for a surgery may make scheduled payments in advance. We will still bill any applicable insurances and only apply your prepaid funds to amounts you are responsible for. Any unused prepayments will be refunded.

**Budget Plans:** Our Central Business Office staff can establish interest free payment plans for large patient balances, and can accept monthly cash, check or credit card payments until the balance is paid in full. An example is 20% at the time of service and then six monthly payments interest free with equal payments.

**Insurances, Health Plans and Medical Benefit Programs:** OGL participates with many insurances. Please call your insurance company at the telephone number provided on your benefit card, and your insurance company can inform you if we participate in your insurance, or if they will authorize you to receive care from OBGYN of Lancaster as an “out of network provider”. Please identify our practice with our Tax ID number, which is 27-0229013.

***For insurances that we participate with:*** We will bill your insurance for you, and accept the contracted payment rates. For office services, if you are required to make a co-payment, co-insurance, and/or deductible we will collect this payment at the time of service. Insurance payment rates may include a portion be paid by the patient, and if so we will invoice you. If the insurer does not provide payment in full according to the contracted amount, the balance of charges is the responsibility of the patient. You are responsible for any amounts the insurance plan deems not covered (or a non-covered benefit), up to the entire amount.

***For insurances that we do not participate with or “out of network provider” or “non-par provider”:*** We do see patients whose insurance OGL does not participate with or who lists OGL as out of network. (We are unable to see patients with government funded medical benefit programs if we do not participate.) Payment or a budget plan completion is required at the time of service. We will provide a receipt and documentation enabling you to seek reimbursement from your insurance. Our prompt payment discount will apply when charges are paid in full at the time of service. Payment plans can be established for large patient balances.

***If we do not hear from your insurance company:*** If we do not receive payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issue.

**Our providers recommend care based on the patient’s best interest,** which is independent of insurance coverage issues.

**Benefit coverage:** We cannot know the benefits and exclusions of each patient’s coverage. Contact your insurance company or employer for this information. When insurers provide information to physicians they always include a statement indicating it is not a guarantee for payment. Therefore, it’s usually best for the patient to contact their insurance company directly.

### **Additional Charges and Fees**

- There will be a \$20.00 fee assessed for all checks returned unpaid by banks.
- Prescription renewals are best completed during your office visit. Prescription refills between office visits may be requested by your pharmacy or by calling OGL 717-393-1338, choosing the prompt for Triage Nurse and using our automated system without additional charges. Office staff are not available for prescription refills after 4:30 PM or on weekends.
- We request at least a 24 hour advance notice if you will be unable to keep your scheduled appointment (please call 717-393-1338 as soon as possible). Our policy is “Failure to provide 24 hour notice to cancel your appointment will result in a No Show Fee of \$25.00.” If you contact us in advance we can reschedule your appointment and avoid a no show fee.

- There is no charge for OGL to issue orders and complete referrals necessary for you to obtain specialized testing or referral to other care. However, if misplaced by the patient there is a \$5.00 fee if the paperwork must be completed or sent a second time.
- Completing disability insurance forms and employer forms is not a medical service and is not paid by insurance. There is a \$15.00 fee for completing a form. Please provide at least one week notice or lead time for completion. Provide a pre addressed envelope for mailing or a FAX # if requested.
- There is a fee for copying medical records which complies with PA State law. A legal release is required.

**General Consent:** You will be asked to complete “General Consent to Treat/Patient Authorization for Release of Information/Assignment of Insurance Benefits/Receipt of Notice of Privacy Practices/Personal Representative” upon check in for your appointment. A copy of this form follows for your information.

**We thank you for choosing our physicians, certified nurse midwives and staff as a partner for your healthcare needs. As always, providing high quality healthcare to you remains our primary purpose.** If you have any questions about this information, please feel free to ask your provider, or ask a Patient Services Representative at Check-In/Check-Out, or call our Central Business Office at 717-519-1550 for more information.

**Lancaster Medical Group dba OBGYN of Lancaster**  
**General Consent to Treat/Patient Auth for Release of Information/Assignment of Insurance Benefits/Receipt of Notice of Privacy Practices/Personal Representative**

The following are the conditions for services provided by OBGYN of Lancaster for the patient whose name appears at the bottom of this page.

**Consent for Medical Treatment**

I/we voluntarily consent to medical treatment and diagnostic procedures provided by OBGYN of Lancaster and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I am, or we are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**Authorization for Release of Information**

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/we voluntarily consent to the practice and physicians obtaining medication history.

**Assignment of Insurance Benefits**

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and OBGYN of Lancaster. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that OBGYN of Lancaster can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. I/we have provided complete insurance information, and acknowledge it is my/our responsibility to update this information if it changes. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

**No Show Appointments**

Please note we require a minimum 24 hours notice (one business day) to cancel your appointment. With proper notice we may offer the appointment time to other patients. Failure to provide 24 hour notice to cancel your appointment will result in a No Show Fee of \$25.00.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

**Personal Representative**

In addition to myself, I designate the following individual(s) as my personal representative and grant OBGYN of Lancaster permission to disclose (written and verbal) my protected health information with the individual(s) named below.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
Name of Representative Relationship to Patient Name of Representative Relationship to Patient

To change my personal representative(s) at any time a new form or written document will be completed.

\_\_\_\_\_  
Date Signature of Patient (Parent, Guardian or Legally Authorized Representative)