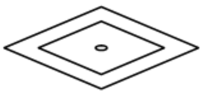

Truthful Insurance Reporting and Notification of Changes in Coverage and/or Care

PREGNANCY

Pregnancy is an insurance state that requires our office to bill for your care at its conclusion. This is referred to by your insurance company as a Global Package, which includes payments for your prenatal care, delivery (vaginal or cesarean section) and post-partum services. Since claims are not submitted on a visit by visit basis, their timely filing can become affected if you should change providers, change insurance, or stop your care mid-pregnancy. Timely Filing is a requirement by your insurance company that all claims for a service be submitted within 90 days of the rendering of care. If you complete your pregnancy care with our office this 90-day window would begin with your delivery date.

If you leave our office before completing your pregnancy care then the 90-day window will be from the date of your last office visit. **It is your responsibility to notify us of any change in your care (changing offices or changing insurance plans)** so we can bill the appropriate insurance company in a timely fashion. If you should leave our care without notifying the office then there is a possibility your insurance claims will not be filed timely in which case your insurance will not cover any of your care with us.

GYNECOLOGY

Timely and appropriate filing of insurance claims also applies to Gynecologic Care. Withholding truthful and accurate information at the time of your office visit regarding ALL of your insurance coverage may result in claims being filed in the wrong order, which will delay timely filing with the correct insurance company. This can result in a denial of payment by all of your insurance plans. This will result in a debt with our office that you will be personally responsible for regardless of any insurance contract. **It is not possible for our office to comply with insurance contract requirements if you are omitting coverage information or providing inaccurate or fraudulent information to our office.**

In summary, in seeking care at our office we have an expectation that you are providing truthful and accurate information for us to bill the appropriate parties (insurance, etc.) for services provided to you. Lack of notification of a change in care, such as leaving our office or changing insurance plans, or the provision of inaccurate or fraudulent insurance information, including omission of any insurance plan you are covered by at the time of service, will result in a debt owed to our office for which you will be personally responsible. There is no timely way for us to become aware of your change in care unless you notify us of these events when they occur.

By signing below, you acknowledge that you have been made aware of the above insurance requirements and accept your financial responsibility for expenses incurred with our office if your insurance denies payment for any of the above reasons. This form supersedes any other contracts in effect at the time of your visit.

____________________________________ __________________

Patient Signature Date

____________________________________ __________________

Witness Date