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Sean M. Keeler, M.D., FACOG

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have questions or concerns about our payment policies, please do not hesitate to ask our billing manager.

All deductibles, co-payments and applicable charges are due at the time of services – NO EXCEPTIONS. All surgery fees MUST be paid in advance of the surgical date – NO EXCEPTIONS. We accept cash, checks, and for your convenience, MasterCard, Visa, Discover and American Express. If **Desert Perinatal Associates** is affiliated with your preferred provider (contracted insurance company), we will submit the claim to your insurance company. If your insurance coverage/company changes, it is your responsibility to notify our office immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. You are responsible for these amounts.
3. YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS. Does your insurance require a Primary Care Physician (PCP) Referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of assistance, please let us know.
4. If the insurance company does not pay in full within 30 days, we ask that you contact the insurance carrier. If your insurance does not pay in full within 45 days, we require you to pay the balance due with cash, check, or credit card.
5. Returned checks for insufficient funds are automatically transferred to a collections agency. You are responsible for all related fees. We reserve the right to refuse payments made by check.
6. Patient balances over 60 days will be patient's responsibility and will be subjected to interest charges of 2% per month whether or not arrangement for payment has been made.
7. You are responsible for any collection fees, legal fees, or court costs.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Signature of patient ____

Date_________________________________

Print Name ____

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