Coast OB-GYN
366 San Miguel Dr. #209
Newport Beach, CA 92660
Phone: 949-520-7078 Fax: 949-209 4177

CREDIT POLICY

Welcome to Coast OB-GYN. The following outlines our patient financial responsibility policy.

Payment for services provided by Coast OB-GYN is required at the time of service unless prior arrangements have been made or you are insured by a company that has a current contract with Coast OB-GYN. Deductibles and non-covered services are due at the time of service. If we are contracted with your insurance company, we will bill your insurance company for you. It is your responsibility to determine what services your insurance will cover and whether a referral is required for you to be seen at Coast OB-GYN or by another provider. If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this to your health care provider. Coast OB-GYN will bill a secondary insurance.

If Coast OB-GYN is **not contracted** with your insurance company and you need a major medical service (such as having a baby or needing surgery), we will provide you with the opportunity to meet with a Patient Financial Counselor. The counselor can help you estimate the cost of the medical services supplied by Coast OB-GYN. A financial agreement form will be completed which should include the cost of the surgery, any deductible due, an estimate of your insurance payment at out-of-network rates and an estimate of the amount that you will need to pay for the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged if necessary. As a courtesy, we will bill your insurance for you. When you receive the statement for your services, you are responsible for payment at that time.

All medications and medical supplies provided by Coast OB-GYN. should be completely paid for at the time of service. Services provided by outside laboratories such as the reading of PAP tests and/or biopsies will be billed directly to you by the outside provider.

You will receive a statement showing in detail charges incurred during the statement period and the amount due. All fees are payable within 30 days of receiving the statement. As the patient, you are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE BILLING POLICIES OF COAST OB-GYN. AND AGREE TO COMPLY WITH THEM.
I AUTHORIZE IRVINE OB/GYN TO RELEASE TO MY INSURANCE CARRIER AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE UNDER THEIR COVERAGE.

I FURTHER AUTHORIZE MY INSURANCE COMPANY AND ITS CARRIERS TO DISCLOSE ANY INFORMATION REQUESTED REGARDING CLAIMS FOR MEDICAL BENEFITS TO COAST OB-GYN. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO COAST OB-GYN FOR SERVICES FURNISHED TO ME BY ITS PHYSICIANS AND STAFF UNLESS I HAVE PAID FOR THE SERVICES AND AM BILLING THE INSURANCE DIRECTLY.

_____ _____
PATIENT NAME (please print) Date of Birth

_____ _____
PATIENT SIGNATURE Date