Partridge Creek
Obstetrics & Gynecology

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WELCOME TO OUR PRACTICE

As a service to you Partridge Creek Obstetrics & Gynecology participate with Medicare, Blue Cross and many insurance plans. We will submit claims to your insurance company for the medical service that has been provided to you. In the event your insurance claim is denied, you will be held responsible. If you have BCBS Master Medical coverage you will be requested to pay at the time service is rendered. It is important that you know what your insurance plan covers. Co-payments, deductibles and non-covered services must be paid in full at the time of service.

If your insurance is a Managed Care Plan or HMO, please review your coverage. If your visit requires a referral from your primary care physician (PCP) a copy of the referral form must be received by this office prior to your visit. Failure to obtain necessary authorization(s) often leads to delays or the need to re-schedule your appointment and out of pocket expenses. We are happy to assist you with your managed care plan, however, understanding your specific plan requirements and allowing adequate time to obtain authorization/referrals is essential.

Your physician is here to handle your medical care and well being. The physicians are not experts on insurance and are not always aware of financial arrangements made. Please discuss insurance and financial issues with the business office staff.

If your are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements.

☐ **MEDICARE AUTHORIZATION** (check if applicable)
I request that payment of Medicare benefits be made to the Physician and or Physician associates providing services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that the payment be made and authorizes release of medial information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claims forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases the physician agrees to accept the charge determination of coinsurance, or non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

☐ **INSURANCE AUTHORIZATION** (check if applicable)
I request that payment of authorized benefits be made to the Physician or Physician associates for any services furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim (s).

I understand and accept the above statements

Signature of Beneficiary (Parent or Guardian) Date

Witness

We sincerely appreciate your cooperation and are happy to assist you in any way we can