General Office Information

- Office Hours: Monday – Friday 8:00am – 4:30pm. The office is closed from 12:15pm – 1:15pm for lunch.
- If you have an emergency after hours, holidays or weekends, please call your primary OB doctor.

Office Policies

- It is required that all patients with scheduled appointments arrive at least 15 minutes prior to the appointment. If you arrive late for a scheduled appointment, you may be rescheduled
- **If you are expecting a guest to attend your ultrasound, they must arrive before your scheduled appointment time. Guests arriving after the ultrasound has begun will NOT be escorted back to exam room.**
- **Limit 2 guests during the ultrasound examination, which includes children 3 years of age and older. All children under the age of 5 must be accompanied by an adult other than the patient.**
- **Camera, cell phone and/or video equipment in the exam room is against SCMFM policy.**
- It is your responsibility to ensure that your insurance company is In Network with SCMFM.
- Co-pays are due before services are rendered. Please pay the receptionist any co-pays and/or costs.
- Non-insured patients are required to pay cash for services prior to the appointment. Cash pay discounts are arranged through our billing department.
- If for any reason insurance fails to pay for services, we will require payment from you.
- Federal Law prohibits access to your information by other individuals including spouses unless written authorization is acquired.
- A release of medical records requires a form to be completed in its entirety and can take up to 14 business days to fulfill.
- There is a $30.00 service fee charged for all returned checks.
- Outstanding balances over 60 days will be sent to collections.

I understand that I am responsible for charges associated with medical services and agree to pay bills upon receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance company to make payment directly to Southern Colorado Maternal Fetal Medicine. I have received/been offered a copy of the Southern Colorado Maternal Fetal Medicine privacy policy.

Patient Signature_____________________________________ Date________________

Printed Name____