

## Southren Colorado Maternal Fetal Medicine

### 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**
- 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 for services prior to the appointment
- 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

### Patient Financial Waiver

It must be understood that:

- Patients are personally responsible for knowing and understanding their own Insurance policy, eligibility and coverage. Verification of coverage is not a guarantee of coverage or payment
- If needed, it is the responsibility of the patient to obtain insurance authorizations. Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the services
- Patients are financially responsible for payments of all deductibles, co-insurance amounts, non-authorized procedures, and non-covered services
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.
- It is responsibility of the patient to ensure that your insurance company is in network with SCMFM.
- There is a \$30.00 service fee charged for all returned checks. Outstanding balances over 90 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