Partners in Obstetrics & Gynecology
A division of Southern New England Healthcare for Women, LLC

Patients Financial Policy

Participating Insurance

- Partners in OB/GYN participates with most medical insurance plans in the area.
- We will file a claim on your behalf and accept contracted payments for covered services.
- You are responsible to pay for plan deductibles; co-insurance and co-payments associated with the services rendered (out-of-pocket expenses).
- You are responsible to pay for services that your medical insurance plan does not cover or that they determine are not medically necessary.
- Co-payments will be collected at the time of service. If not, a $5.00 fee will be charged.

Non-Participating Insurance

- If Partners in OB/GYN does not participate with your insurance plan, you are responsible for payment of all charges associated with the services you received.

No Insurance

- Payment is expected at time of service.
- Payment plans are available but must be established before services are rendered.

Outstanding Balances

- Patients with an outstanding balance with Partners in OB/GYN will be expected to pay that balance, or commit to a payment plan before additional services are rendered.
- Outstanding balances may include co-insurance, co-payments and/or non-covered services from prior visits, etc.
- Outstanding balances may also include amounts due for services provided by our physicians at Partners in OB/GYN or Women & Infants Hospital.
- We reserve the right to reschedule your appointments if you have a balance that is greater than 60 days, have been sent to collections, and/or no payment arrangements have been made.

Billing Department representatives are available Mon – Fri from 9:00 a.m. to 4:30 p.m.; please call (401) 724-0600. We accept cash, personal checks, MasterCard, Visa, American Express, and Discover.

We reserve the right to charge $50.00 for appointments cancelled or broken without a 24-hour advance notice.

Please read and sign below

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Partners in OB/GYN. I understand that I am financially responsible for balances not covered by my insurance carrier. A copy of this signature is valid as original.

_____ _____ _____

Signature of patient or responsible party **Date** **Account Number**

THANK YOU FOR CHOOSING PARTNERS IN OBSTETRICS & GYNECOLOGY