



Bellegrove Obstetrics & Gynecology Inc., P.S.

1200 – 112th Ave NE
Suite C-115
Bellevue, WA 98004
425-455-0244 425-455-9411 FAX
www.bellegroveobgyn.com

FINANCIAL POLICY

Welcome to our office. We strive to provide the highest quality health care in a pleasant and supportive atmosphere. To make our relationship more comfortable, we offer the following information on our financial policies. Please review this information carefully. To avoid misunderstandings, we suggest that you discuss your needs with our staff. We will be happy to answer your questions and assist you in any way we can.

REFERRAL REQUIREMENTS

Some insurance plans require a referral from a primary care physician for services in our office to be covered. Other companies will waive this requirement if your visit is for your annual gynecological exam. Reimbursement and deductibles may also change depending on whether your visit is for a “wellness” or “sickness” reason. It is important that we code your bill correctly; therefore PLEASE BE AWARE OF YOUR PLAN REQUIREMENTS!

INSURANCE BILLINGS

Our office can submit primary insurance if you provide us with your ID card and insurance forms. If you have a secondary insurance, we can provide you with an itemized statement for you to submit to your carrier.

Please be prepared to pay the "co-payment" portion of your bill at the time of service.

If you are being seen for obstetrical care, be aware that the billing procedures for this care are somewhat different than for other services. Please speak to our insurance administrator or business manager if you are establishing yourself as an OB patient.

Our staff will help you with billing in any way we can; however, our office cannot be responsible for collecting or negotiating a disputed insurance claim. In most cases, regardless of your coverage, you are responsible for the entire account.

OVERDUE ACCOUNTS

Charges are due and payable when rendered. We request payment at the time of service unless prior arrangements have been made with our business manager. If you are an established patient, we will extend you the courtesy of a monthly bill. Please be aware, however, that payment is expected within 30 days of billing. A monthly service charge will be applied to all accounts beyond 30 days. If you are having difficulty paying your bill in full, please discuss this with our business manager. Often, she can arrange a payment schedule.

Thank you for your attention to these matters. By signing below we ask that you acknowledge receipt of this information.

SIGNED: PATIENT OR PARENT _____

DATE _____