Scenic City
OB/GYN, Inc.

Blending technology and caring into optimum women's health

OBSTETRICS AND GYNECOLOGY

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****PAYMENT AGREEMENT****

I have read and understand the Patient Information form provided for me by Scenic City OB/GYN, Inc. and do hereby confirm that all the information I have supplied in the completion of this form is true and correct, to the best of my knowledge.

I also agree to notify Scenic City OB/GYN, Inc. of any changes in the information I have provided, either health status or general patient information, on a timely basis or upon my next scheduled appointment with Scenic City OB/GYN, Inc.

I hereby acknowledge that I am ultimately responsible for full payment of any and all fees or charges for services provided to me by Scenic City OB/GYN, Inc. and that the filing of insurance claims with any health care coverage I may hold is a courtesy to me and does not in any way relieve me of financial responsibility for any balance remaining after insurance payments, **including any amount that exceeds my insurance company's usual, reasonable, and customary rate.**

PLEASE NOTE:** If we are a participating provider with your insurance company, we will follow contractual obligations.

I understand that if this visit has not been authorized by my Primary Care Physician and I have no referral number, the service(s) I receive may not be covered by my health care benefits plan and I will be responsible for payment in full for services rendered. **(NOTE: This paragraph applies to patients who require a referral number from their PCP.)**

I also understand that certain procedures may not be covered by my insurance plan and that if I request a non-covered service, I will be financially responsible for those services and agree to pay any and all non-covered fees and charges. (NOTE: This paragraph includes patients with Medicare, Medicaid and/or TennCare.)

I am aware that my co-pay, co-insurance, and/or deductible is due at the time services are rendered.

*****IF YOU HAVE TENNCARE AND/OR MEDICAID AND DO NOT INFORM US OF COMMERCIAL INSURANCE COVERAGE, YOU WILL BE REQUIRED TO PAY IN FULL FOR ALL SERVICES PROVIDED. ALL INSURANCE INFORMATION MUST BE PROVIDED IN A TIMELY MANNER.*****

I understand that I will be billed a $5.00 monthly service charge on any balance 120 days past due. In addition, should my account ever be turned to a "collection agency", I will be responsible for any and all collection costs, including attorney fees and any court costs.

_____ Date: _____
Signature

_____ Date: _____
Parent (if minor)