Financial Policy

Welcome to Preferred Gynecology and Thank You for choosing us as your healthcare provider. At your initial visit, we ask you to read and sign this financial policy, which will be kept in your file.

Please let us know if you have any questions or concerns.

The practice accepts most insurance plans, and we participate as an in-network provider with most plans. It is your responsibility to make sure we are in-network with your particular plan. Preferred Gynecology requests that patients bring a copy of their identification card and insurance card to their appointment. Please notify us of any insurance changes immediately. Payment for all co-pays, deductibles, coinsurances and services that are not covered by your insurance is expected at time of service, UNLESS arrangements have been made PRIOR to your appointment. The office accepts credit cards (Visa, and Mastercard) as well as personal check and cash. A returned check will carry a fee of $40.Prior to surgery, we will call to obtain an estimate of your benefits (THIS IS NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY), as well as your estimated payment. We will inform of you of the information prior to your surgery.

A statement will be mailed to you. Payment is due within 30 days of the bill. A finance charge of 8% will apply for bills that are more than 60 days outstanding. After 90 days, the account will be turned over to collections. Please realize that a 42% collection services charge will be added to the bill when it is turned over to our collections agency.

Should you desire a copy of your records, we will gladly provide them after a signed Records Release is received by our office. The charge for copying records is based on the guidelines as outlined by the Texas Medical Board under the Texas Medical Practice Act.
Please bring your medical forms with you to your appointment. Certain forms may have a $20 charge for completion. Please inquire at the front desk.

I certify the insurance information I have provided is correct to the best of my knowledge, and I agree to pay all balances due at the time of service plus any additional balance my insurance deems my responsibility once my claims have been processed. I also certify I have read and understand the financial policies as outlined. All of my questions have been answered.

PATIENT
SIGNATURE_____ DATE_____

PRINT
NAME_____ D.O.B._____

PARENT OR LEGAL
GUARDIAN_____ DATE_____