RWJ OB-GYN ASSOCIATES, P.A.

50 Franklin Lane
Manalapan, NJ 07726
732-536-7110

3270 Route 27
Kendall Park, NJ 08824
732-422-8989

525 Route 70
Lakewood, NJ 08701
732-905-6466

POLICY FOR PAYMENT OF SERVICES

Payment is due at the time of service. However, if we participate with your insurance plan, we will file a claim for assignment of medical benefits. Co-payments are due at the time of service. It is your responsibility to know and understand your insurance policy and the coverage of benefits it provides. I clearly understand that I am responsible for any amount not covered by my insurance for any reason. I will also be responsible for any co-pays, co-insurance, and deductible amounts. Any payments made directly to the patient and owing to the physicians will be remitted immediately to ***RWJ OB-GYN Associates.*** It is your responsibility to obtain referrals, if necessary, prior to treatment. If incorrect information is given to the office, and benefits are denied, we cannot change or correct the billing after the fact. It is your responsibility to contact your insurance company.

FINANCIAL RESPONSIBILITY AGREEMENT

I, the undersigned, hereby authorize assignment of medical benefits to ***RWJ OB-GYN Associates,*** including Drs. Rathauser, Bochner, Lundberg, Segal, Ham, and Uxer. This is an irrevocable transfer of benefits allowing the right to appeal and litigate. This allows ***RWJ OB-GYN Associates*** to exercise the right to accept or deny an appeal. I hereby authorize release of all medical and any other information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand if my account becomes delinquent, and is sent to a collection attorney or collection agency, I will be responsible for an additional collection fee of $50 or 20% of the balance owed, whichever is greater.

PLEASE PRINT FIRST AND LAST NAME

_____ _____

Printed FIRST NAME Printed LAST NAME

_____ _____

PATIENT'S SIGNATURE DATE