ROBERT D. PLAMBECK, M.D., P.C.
Obstetrics & Gynecology

FINANCIAL POLICY

Welcome to our office. Please read this information about our financial and billing policies. If you do not have insurance, you must pay at the time of service or make other arrangements with our billing staff. We accept cash, personal checks, MasterCard, Visa and Discover.

If you have insurance, we will file claims on your behalf. We must have your current insurance and policy holder information and you are authorizing payment directly to us. If your insurance requires co-payments, you must pay that amount at the time of service. You are responsible for paying us for any services not covered by insurance, such as infertility and elective services. Non-covered charges/Ineligible charges will be excluded from the PPO discount.

We will send you a monthly statement so that you know when your insurance company has made a payment and the amount of the remaining balance. Payment is due upon receipt of the monthly billing statement. Even if you have insurance, **payment to us is your responsibility**. If you are self-pay, you will be expected to pay for the visit at the time of service.

You should know the details of your insurance plan. Many insurance plans require you to use certain hospitals, providers or labs and may require pre-certification or referrals to another facility. We are not responsible if you are sent to the wrong facility. You also need to know which doctor, hospital, or lab your plan requires you to use.

If your medical care is the result of a motor vehicle accident or other liability accident, you will need to let us know at the time of the service if the insurance claim should be sent to your private health insurance or if the claim needs to be sent to another carrier.

In the case of divorce, the custodial parent is responsible for all payments. We are not involved in disagreements between the parties in a divorce situation

You may be billed by other providers for other services such as laboratory services, etc.

Accounts not paid in full within 60 days are considered past due and a finance charge will be applied. If you are unable to make full payment and would like to arrange a monthly payment plan, please contact our office. There is a charge for returned checks and we use a collection agency when necessary.

It is your responsibility to contact us to discuss potential eligibility for other financial assistance programs based on stipulated income requirements. We will go back only 60 days from the date of notification of secondary insurance or Medicaid.

Please call our office 24 hours in advance to cancel your appointment. Missed appointments without notification are considered "NO SHOW" appointments. There will be a $20 fee assessed which will need to be paid in full prior to scheduling any further appointments. If you "no show" more than 3 time in one year, you may not be allowed to schedule a visit.

If you have any questions about this information, please call our office at 402-486-4800. Initials: _____

Consent for Communication: I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to the office of Robert D Plambeck, M.D., P.C. and to any of their service providers now and in the future, may be used as a means to contact me. I also agree that this office and any other service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice or text and disclose the nature of communication. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective. Initials: _____

HIPAA Compliance: I have read and understood the HIPAA policy presented to me by the office of Robert D Plambeck M.D., P.C.
Release of information: I give permission for the office of Robert D. Plambeck, M.D. to discuss my medical and/or financial information with the following person(s) in accordance with their HIPAA policy:

Name	Relationship	Phone	Med Info	Financial Info	Initials
1. _____			Y N	Y N	_____
2. _____			Y N	Y N	_____

I understand and agree to the policies explained to me by the office of Robert D. Plambeck, M.D., P.C.

Signature: _____ Date: _____