Bend Gynecology Financial Policy

1. I hereby authorize payment directly to Dr. Lauren O'Sullivan and her associates, all insurance benefits otherwise payable to me for services rendered.

2. I understand that I am financially responsible for all charges not covered by insurance and for all services rendered on my behalf.

3. I understand that I may also obtain charges from outside facilities related to my visit (i.e., lab, pathology, hospital).

4. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure payment of benefits.

5. I authorize the use of this signature on all insurance submissions.

6. I understand that a **late fee of $25** will be charged on outstanding **balances 60 days after date of service.**

Cancellation Policy

Cancellations significantly impair our ability to care for patients who are waiting for medical care. Therefore, we require **adequate notice** to cancel or reschedule your appointment for ANY REASON.

The following guidelines will be used:

Office visit requires **> 24 hours' notice** or you will be **charged $50**.
Office procedure requires **> 72 hours' notice** or you will be **charged $100**.
Hospital surgery requires **> 30 days** or you will be **charged $500**.

This does not apply to those that keep their appointments or give more than the required notice.

We truly appreciate your business and ask that you appreciate ours.

_____	_____	_____	_____
Patient Signature	Date	Guardian's Signature (If patient under 18)	Date

Revised 12/08/22