

## **Bend Gynecology Financial Policy**

1. I hereby authorize payment directly to Bend Gynecology (Lauren O’Sullivan, D.O., LLC) all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance and for all services rendered on my behalf. I understand that I may also obtain charges from outside facilities related to my visit (i.e., lab, pathology, hospital).
2. 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.
3. I authorize the use of this signature on all insurance submissions.
4. 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 visits** require > **24 hours notice** or you will be **charged \$50.**

**Office procedures** require > **72 hours notice** or you will be **charged \$100.**

**Hospital surgeries** require > **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