Drs. Schwartzenburg, Lafranca, & Guidry
Obstetrics & Gynecology
A Professional Medical Corporation

Clifford J. Schwartzenburg, M.D.
Ellis J. Schwartzenburg, M.D.
Ann M. Lafranca, M.D.
Edward Schwartzenburg, M.D.
Kathy H. Guidry, M.D.
Cheree A. Schwartzenburg, M.D.

Thank you for choosing our clinic to provide your OB-GYN health needs. Because of managed care confusion and the fact that we contract with some 600 components and subsets of insurance companies, it is impossible for us to keep current with all of the individual portions of each contract as it relates to each patient and employee group.

We must ask you, the patient, to be responsible to know exactly what coverage your insurance company will allow for office visits and procedures, and what lab your insurance company has contracted for pap smears, biopsies, cultures, blood work, etc. We also are asking for your help in determining whether referrals from or to the primary care/specialists are necessary.

Because of the above confusion, we are asking that you read and mark off appropriate parts of this disclosure/agreement:

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Disclosure/Agreement

Date: _____

Patient Name: _____

Reason for today's visit

[ ] Routine Preventive Exam (I have no medical complaint or significant problem abnormality that I am aware of).
[ ] I have a problem/complaint that I wish evaluated/treated by the doctor. My Chief Complaint is: _____
_____

****

[ ] My insurance plan covers Preventive Medical Services.
[ ] My insurance plan does not cover Preventive Medical Services.
[ ] I don't know if my insurance plan covers Preventive Medical Services.
[ ] My insurance plan requires a referral for problem visits.
[ ] My insurance plan does not require a referral for problem visits.
[ ] I don't know if my insurance plan requires a referral for problem visits.

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, which are filed in accordance with contract guidelines, for whatever reason. This office will file a claim in my behalf, however if my insurance company denies payment for some of the following reasons (e.g. non-covered services, does not pay for preventive medical visits, my failure to obtain certification/authorization prior to procedure), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask the office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

OVER

I am responsible to know which laboratory my insurance carrier allows me to use for any lab tests including pap smears, biopsies, cultures, and blood work. I am also responsible to notify my physician of this. Please circle one of the following laboratories:

Woman's Hospital Lab **Lab Corp.** **Quest**

Unless otherwise notified, lab work will be sent to Woman's Hospital Laboratory.

I agree to pay my portion of the bill at the time of my office visit (including co-payment, co-insurance payment and deductible payment.) If I do not pay for services provided, at this time, I agree to pay a $15.00 statement processing fee as part of the collection process.

By: _____

Patient Signature (If patient is a minor, responsible party must sign.)

Drs. Schwartzenburg, Lafranca, & Guidry have provided me with a copy of their office Notice of Privacy Practice (HIPPA).

Signature: _____

Date: _____