OB/GYN Associates of Lancaster, Inc.

1532 Wesley Way
Lancaster, Ohio 43130-3387
Phone: (740) 653-5088
Fax: (740) 653-6361

Sarah L. Froman, MD, FACOG
Laurel J. Santino, MD, FACOG
Suzanne M. Barnhart, MD, FACOG
Brandie J. Shirey, MSN, CNP

PAYMENT RESPONSIBILITY WAIVER

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____

1. I understand that the provider of services DOES participate with my insurance. If for some reason my insurance denies payment, I accept the responsibility for payment of charges for services. I also acknowledge that I am responsible for payment for any co-pay required by my insurance at the time of service.
2. I understand that the provider of services DOES NOT currently participate with my insurance carrier. Further, I understand that the provider will submit my claim for today and any future visits. I accept responsibility for payment of the entire charge for services rendered at the time of service.
3. I wish to pay for services out of pocket and to NOT have these charges submitted to my insurance carrier.

In signing this, I also acknowledge that I am responsible for notifying OB/GYN Associates of Lancaster, Inc. of any changes in my insurance plan. If they receive denials stating it is past timely filing of my claims due to not having the correct insurance information, I will be financially responsible for the services rendered.

Signature: _____ Date: _____

Printed Name: _____