235 Plain Street
Providence, RI
Ph: (401) 421-1710
Fax: (401) 861-2164

STATEMENT OF FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Bayside OB/GYN, Inc., and Terrence F. Cahill, MD. I authorize payment to Bayside OB/GYN, Inc. or Terrence F. Cahill, MD. I understand my insurance carrier may not approve or reimburse my medical services in full, due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. I understand that I am responsible for paying my provider directly for any policy deductibles, co-insurance or co-payments **within thirty (30) days of service**. Failure to meet these obligations may affect my credit history. I also understand that I will be responsible for any costs resulting in my failure to pay, such as collection fees by a Bayside OB-GYN attorney. **Presenting an invalid or inactive insurance card will result in full responsibility of payment by me.** I understand that if I do not have an authorization for a visit and my insurance requires one that I may be responsible for the full charges of that date of service. If for any reason I cannot make the full required payment, I understand that I may call Bayside OB-GYN to make advance arrangements.

MISSED APPOINTMENT/RETURNED CHECK NOTICE

Due to the nature of our practice, we require a 24-hour notification if you are unable to keep your appointment. There will be a thirty dollar ($30) charge for any missed appointments, less than a 24-hour cancellation notice. There is also a fee for any returned checks.

POLICY OF STATEMENT CHARGES

Insurance co-payments, co-insurance and deductibles are due at the time of service. After ninety (90) days your account will be turned over to collections.

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Patient's Name (Printed)	Date of Birth
______________________________	______________________________
Signature of Parent or Guardian	Printed Name of Parent or Guardian