Patient Name: _____

Patient Health Plan: _____

Patient Mailing Address: _____

Patient Account # _____

Patient Waiver
Collection of Deductible and Coinsurance

We have verified with your insurance carrier that you may be responsible for a payment of a deductible/coinsurance under your insurance coverage. Please sign your name to confirm our agreement regarding payment for services that fall under your deductible/coinsurance portion of your insurance plan.

I understand that I may be responsible for paying Baystate Ob/Gyn Group, Inc directly for a deductible/coinsurance under my insurance coverage. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, Baystate Ob/Gyn Group, Inc. may notify my insurance carrier and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have a longstanding unpaid deductible/coinsurance owed to Baystate Ob/Gyn Group, Inc., Baystate Ob/Gyn Group, Inc may terminate the provider/patient relationship as a result, subject to the requirements of state and/or federal law.

I further understand that if Baystate Ob/Gyn Group, Inc. collects an applicable deductible/ coinsurance from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me, not later than 45 days after the provider's receipt of insurance carrier notification.

Patient/Guardian Signature: _____ Date_____

Print Full Name: _____

Practice Representative: _____ Date_____

Credit Card Holder Information (to be completed by the cardholder if other than patient)

Name of credit card holder: _____

Relationship to patient: _____

I, the credit card holder, authorize Baystate Ob/Gyn Group Inc. to record and store my credit/debit card information prior to my (or the patient's) appointment. Baystate Ob/Gyn Group, Inc. will submit any claims related to my (or the patient's) care to the insurance carrier on file. Upon receipt of notification from the insurance carrier that I (or the patient) is responsible for any applicable deductible and or coinsurance, I authorize Baystate Ob/ Gyn Group, Inc to charge my credit/debit card for any balances owed by me (or the patient).

Card Holder Signature: _____ Date_____

Print Full Name: _____