South Florida Women's Care
Obstetrics and Gynecology
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Miami, FL 33156
Office 305-661-7760
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Lucia Gaitan, MD, FACOG
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FINANCIAL RESPONSIBILITY

I understand that it is my responsibility to be aware of the scope of coverage provided by my insurance carrier. I acknowledge it is not the physician's responsibility to interpret my benefits and assume responsibility of coverage. I understand my laboratory services, including but not limited to other services provided to patient care are not considered medically necessary under their definition of this term. I accept my responsibility for all services rendered by my doctor to me in this regard. I understand that by allowing my blood to be drawn, I authorize the doctor to perform recommended tests and agree to assume all financial responsibility for these tests.

I understand there are services and laboratory tests that may, or will not be covered by my insurance company.

I understand my insurance company may apply a copayment, or deductible fee, once and after services are rendered, and I hereby agree to pay my doctor for that portion which I am responsible for.

I understand as a courtesy, my doctor will bill my insurance company for services rendered, once and after a copay and deductible may be collected, in good faith, for which it feels is a covered benefit.

I understand that if the insurance company denies payment for any reason, I am fully responsible for all outstanding charges. Benefits and fees collected prior to services being rendered are not a guarantee of payment, since payment will be processed at the time the claim is submitted up to insurance company's discretion.

I understand on occasion my healthcare provider may request a copy of my medical records to audit nature of treatment or determine degree of benefit. I hereby give permission to release requested records.

I understand and acknowledge a $35.00 fee for any returned checks.

I agree to pay all legal and other expenses that the doctor may incur because of actions taken to collect unpaid balances for which I am responsible.

I consent the doctor and practice staff to communicate with me via email. I understand email is not a confidential method of communication. I understand that there is a risk associated with using email and communication may be intercepted by third parties or transmitted to unintended parties. I understand all email communications between me, doctor, and medical staff will be scanned and made part of my medical record. I understand I should not rely on email to communicate urgent matters, I should rather call the office, and in case of an emergency go to the nearest emergency or urgent care center.

Patient Name: _____ DOB:_____

_____ _____
Patient / Guardian or Legal Representative Signature Date