Centennial Ob/Gyn

Luis J. López-Benítez, M.D.
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Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept most debit cards, Visa, and Master Card.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible, copayment and coinsurance at the time of service. This office's policy is to collect this payment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the negotiated rate for the service performed. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

Regardless of marital status, we will look to the adult accompanying the patient for payment due at the time of services rendered to minor patients.

Request for Medical Records

In accordance with Nevada law, **Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn)** requires written request for the release of medical records. Our charge is **$0.60** per page if a copy is given directly to the patient. If we are forwarding this information to another physician, this will be done as a courtesy to the patient at no charge. Please take this into consideration when requesting copies of medical records.

Missed Appointments

In the event that you fail to cancel a scheduled appointment at least 24 hours in advance of that appointment time, you will be billed **$35 for a regular appointment** and **$70 for a procedure.** If you

fail to cancel a **scheduled surgery** at least 7 days in advance, you will be billed **$100**. This will be due upon receipt of a statement from our office. Also, if you miss two consecutive appointments, or show a pattern of non-compliance, you will be automatically discharged from the practice.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to **Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn)** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn)** to: (1) release any information necessary to insurance carriers regarding my care; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn)** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I understand and agree that the practice may amend such terms from time to time. I also understand in the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

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Printed Name of the Patient

_____ _____

Signature of Patient Date

Revised 04/09/18