

**Fairfax OBGYN Associates, P.C.**  
**Obstetrics, Gynecology, and Infertility**

**Patient Responsibilities**

1. Notify us of any changes in your address or insurance information at the time of the change.
2. By presenting to us for treatment we will order tests that are medically necessary to take care of you. Please be aware that you will receive a separate bill from the laboratory for any samples sent to the laboratory for analysis such as your pap smear, biopsies or blood work. It is your responsibility to know what tests your insurance policy covers and does not cover and what needs prior authorization and what needs a referral. If you accept services without getting the proper referral or prior authorizations you understand that this means you become responsible for this service. (This includes all laboratory and radiology tests.)
3. All appointments must be scheduled in advance. There will be \$100.00 fee for missed appointments. To avoid this fee please call 24 hours in advance.
4. Co-payments must be made at the time services are rendered. (This is a health insurance requirement.) There is a charge for coming in just for blood work. If you do not wish this charge, you can get your blood work drawn at your laboratory drawing station. We will provide you with the proper request information to take with you.
5. Pay your bill promptly. If there is financial hardship please call (703) 391-1500 and ask for billing in advance of appointment.
6. There is a fee for copying medical records. It is \$10.00 processing fee plus \$.50 per page. Records take 14 days to process so make sure your release form is turned in the appropriate timeframe.
7. There is a \$75.00 fee on all returned checks.
8. There is a \$15.00 charge to complete any kind of form for life insurance, school physical, employment physical or disability forms. Payment is due when the form is turned in. Please give us at least 7 business days to complete the form and get the physicians signature.
9. Please be advised that we will only call you regarding test results that require additional testing or further discussion with your healthcare provider. This will require a consultation appointment. To protect your confidentiality, results will not be discussed over the telephone.

I \_\_\_\_\_ have read and understand the above policies.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date : \_\_\_\_\_

**Thank you in advance for your cooperation and understanding.**