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Accredited with the American Institute of Ultrasound in Medicine
And the Fetal Medicine Foundation

Payment is due at the time of service. The patient is responsible for furnishing accurate insurance information (insurance card) to the receptionist and informing the receptionist immediately if there has been a change in address, marital status, and insurance benefits such as termination or COBRA. **Patients are responsible for verifying their own benefits and limitations with their insurance company, including but not limited to co-pay, co-insurance, deductible, and provider participation.** MFAMA accepts insurance and sends claim information to the insurance companies as a courtesy to our patients. Health insurance is intended to cover some, but not all, of the cost of your treatment. Most plans require a co-pay, coinsurance, and/or deductible, which the insurance company deems a part of the total reimbursement due to the doctor for services rendered. **Maternal Fetal Associates of the Mid-Atlantic, LLC may decline to render further services to the patient if the required fees are not paid at the time of service.**

AUTHORIZATION / AGREEMENT

An attempt has been made by me or on my behalf to obtain authorization from my insurance carrier for the services I am seeking from Maternal Fetal Associates. Even if my insurance carrier has authorized my visit(s) with Drs. Hassan, Maghak, and/or Elkousy, the insurer may deny payment. I understand that the insurance carrier pays Maternal Fetal Associates directly for the services they provide.

I understand that my Obstetrician has referred me to Drs. Hassan, Maghak, and Elkousy for their expertise in Maternal Fetal Medicine and all care they provide to me is done as a medical necessity as determined by my Obstetrician and the physicians of Maternal Fetal Associates. In the **rare** case my insurance carrier refuses to issue authorization or payment for care from Drs. Hassan, Maghak, and Elkousy, I understand that I am financially responsible for any and all charges related to services I receive for such care.

A billing fee of **\$30.00** will be added for failure to pay co-pays, coinsurance, and/or deductible at the time of service. I understand that a monthly late fee of **\$20.00** will be applied for overdue accounts, as well as **interest at 1.5% per month (annual percentage rate of 18%)**, and that I am responsible for any collection agency, attorney and court fees required to collect my balance. In order to accommodate as many critical patients as possible we ask that you give us 24 hours notice to cancel any appointment in order to avoid a **\$100 no show fee**.

My Obstetrician has recommended that it is in my best interest to receive medical and diagnostic services from Drs. Hassan, Maghak, and Elkousy.

I _____, hereby agree to the above terms and conditions and that the
Patients full name, please print

insurance information I provided is accurate and complete.

Patient signature, _____ Date _____

If patient is under 18 years of age, parent or guardian must also sign this form:

Name: _____ Relationship _____
Full name, please print

Signature: _____ Date: _____