ACE OBGYN LLC
STEFAN NOVAC MD
Board Certified Obstetrician Gynecologist
601 N Flamingo Rd Suite 406, Pembroke Pines, FL 33028
Tel: 754-201-3700 • Fax: 754-201-3711

All patients are responsible for the cost of services received at our office. As a courtesy service, and to assist you in the satisfaction of your financial responsibility, prior to billing your insurance company, we will verify what benefits, if any, are available through your insurance plan. Patients are expected to pay all applicable deductibles, co-payments, and any other non-covered patient portions at the time of service.

You are responsible for providing information regarding your insurance company, which includes Coordination of Benefits (COB) information. COB is a process by which insurance companies determine the sequence by which the insurance plans pay benefits - which plan is primary and which plan is secondary. specific forms or additional documentation (insurance cards, authorizations, referrals, claim forms, etc.) are required at the time of registration. Please bring all insurance cards with you to your initial visit. Failure to present the proper insurance information may result in you having full responsibility for payment of all services rendered.

Please note that benefit verification by any insurance company, whether by phone or otherwise does not guarantee payment from an insurance company. You are ultimately held financially responsible to the Provider of service should your insurance fail to pay any insurance claim. We strongly suggest that you know exactly what your insurance benefits are.

Missed appointment Policy: When you make an appointment, professional time is especially reserved to provide for your care. If you fail to appear for your scheduled appointment or fail to give 24-hour notice, your account will be charged $40.00 for that missed appointment.

Guaranty of Payment: I fully understand that I am directly responsible for payment to ACE OBGYN, LLC for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered unless other arrangements have been made. I agree to pay all collecting costs including reasonable attorney's fees in the event it becomes necessary to file suit for payment. I authorize payments to be made directly to ACE OBGYN, LLC Authorization to Release Information. I hereby ACE OBGYN, LLC formation acquired during my visit or treatment to my insurance company for the purpose of processing any insurance claim**.**

Assignment of Insurance Benefits: If insurance claims are filed on my behalf, I hereby authorize direct payment of any benefits to ACE OBGYN, LLC. for any treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of this authorization to be used in place of the original. In addition, I authorize ACE OBGYN, LLC. to access records of my prescription medications directly from the pharmacy whenever it is deemed necessary for my care.

Patient signature: ______________________________ Date: __________