

South Shore/Hanover Obstetrics and Gynecology, Inc.

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PAYMENT POLICY

I acknowledge receipt of services rendered to me or my dependents by South Shore/ Hanover OB/GYN.

I agree that payment in full is my ultimate responsibility despite insurance coverage or determination. Our billing office will pursue every effort to bill your insurance and collect for your services. In case my insurance pays part of the bill. I agree to be responsible for the balance.

Medicare will only pay for services it sees as “reasonable and necessary” under the Medicare law. If Medicare decides that a particular service is “not reasonable and necessary” under its program standards, Medicare will not pay for the service. You will be responsible for the charges incurred.

Mass Health of Medicaid will not pay for any infertility treatments and I agree to for the charges incurred.

I agree to provide a valid referral should my insurance company so require.

I authorize the release of medical information necessary to process insurance claims and I authorize South Shore/Hanover OB/GYN to receive payment for services rendered from my insurance company.

Signature: _____
(Patient/Parent/Guardian)

Date: _____