

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## WOMEN'S HEALTH PARTNERS FINANCIAL POLICY

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
  - ~Bring your current insurance card to every visit and notify us of changes in coverage.
  - ~We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company may be billed to your secondary payer. A monthly statement will be sent to you. *Ultimately* you are responsible for payment of charges.
  - ~Be prepared to pay your co-pay at each visit. Payment can be made by cash, check Mastercard, Visa or Discover.
  - ~I understand that my insurance carrier can choose to assign benefits to Women's Health Partners or my insurance carrier may make payment directly to me.
  - ~I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible or charges for non-covered services provided to me or any of my dependents.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however should be directed to your insurance company member services department (number should be on your insurance card)
4. This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require other treatments for illnesses or problems may be charged separately for each service even when both services are provided on the same day.
5. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a collection charge of \$50.00 for balances up to \$150.00 and for balances of \$150.01 and higher the fee is 35% of the outstanding balance.
7. There will be a fee charged for all appointments that were not kept and/or not cancelled 24 hours prior to the appointment time.
8. Co-pays not paid at time of service may result in a processing fee.
9. There is a \$30.00 fee on all returned checks.
10. There is an additional fee for all office visits scheduled after posted hours. Emergency visits/walk-ins/non-scheduled appointments will be charged an additional fee.

Patient's Initials \_\_\_\_\_

11. There is a fee to copy any or all medical records. This fee is regulated by the State of Ohio.
12. There is a fee for FMLA and/or Disability forms. This is a per form fee to be paid prior to the forms completion.
13. Yearly well woman exams may or may not be covered under your health insurance policy, however, they may be required by your physician. Some forms will not be filled out and/or signed if physicals are not up to date.
14. If you miss or no show for three (3) appointments you may be dismissed from the practice.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I certify that I will pay Women's Health Partners any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Women's Health Partners any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

I understand and agree that if my account is delinquent, Women's Health Partners may deny me or my dependent, as named below, further supplies and services or may require that I pay for supplies and services at the time of the visit.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if given false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

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PRINT PATIENT'S NAME

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DATE

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SIGNATURE OF PATIENT OR GUARDIAN

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WITNESS