FINANCIAL POLICY STATEMENT

Insurance Plans

Please feel free to discuss any concerns you have about this policy statement or your insurance benefits with our front office staff prior to your appointment or seeing the physician. If a referral is required from your Primary Care Physician, it must be received in our office prior to, or at the time of, your appointment.

If your insurance provider has not paid for services in full within **60** days, you may be billed for the balance. Women's Health Wise will not be responsible for billing or collecting from another party, i.e. divorced or separated spouse. It is understood that any monies received by Women's Health Wise from you or your insurance provider over and above your indebtedness will be refunded to you or your insurance provider, as is determined to be appropriate.

Your insurance card must be presented at each visit in order for charges to be submitted to your insurance provider. If for any reason your insurance coverage changes while under our care, Women's Health Wise must be immediately notified of such change. *Failure to notify us of insurance changes may result in denial of your insurance claim and all monies owed will be your responsibility.* Insurance providers will **NOT** accept claims prior to the plan's effective date. For large or unexpected charges not covered by your insurance provider, payment arrangements will be considered.

Initial: _____

Co-Payments and Deductibles

Although we may be participating providers with your insurance company, all co-pays, deductibles and non-covered services must be paid at the time of service. We accept cash, checks, Visa, MasterCard, and Discover as forms of payment.

Initial: _____

Minors / Full Time Students

Parent(s)/Guardian(s) are responsible for payment of all charges incurred by a minor that are not covered by an insurance policy. The parent/guardian arranging services for the minor will be considered responsible for payment. Women's Health Wise will not be responsible for billing or collecting from another party, i.e. divorced or separated spouse. For unaccompanied minors, treatment will be denied for non-emergency services unless insurance coverage has been verified, charges have been pre-authorized to a Visa/MasterCard/Discover, or paid by cash or check at the time of service.
Please complete Minor Registration Form

Initial: _____

Outstanding Balances

If you have an outstanding balance, future appointments and treatment may be denied for non-emergency services until the outstanding balance is paid in full.

Initial: _____

Collection Accounts

Outstanding balances in excess of **60** days may be sent to a collection agency. No additional appointments will be scheduled for patients that have been placed with a collection agency. A service charge of 1.75% per month (21% APR) will be added to unpaid accounts after **60** days. In the event you default, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be the greater of $30.00 or 30% of the principal balance will be added to your account. You may also be billed for any LEGAL FEES incurred as a result of default.

Initial: _____

Not Sufficient Fund checks

If at any time you give us a check that does not initially clear the bank, you will be notified by our office and your account status with us will be cash only as an acceptable form of payment. You will also be charged a processing fee of $35.00 which will be added to your outstanding balance.

Initial: _____

No Call No Show Policy

If at any time you are unable to attend your scheduled appointment we request 24 hour notice prior to appointment time. If you do not call or come to your scheduled appointment the following policy will be enforced:
1st missed appointment: Courtesy call to reschedule.
2nd missed appointment: Courtesy call to reschedule. $25.00 inconvenience fee.
3rd missed appointment: Courtesy call to reschedule. $50.00 inconvenience fee.
4th missed appointment: Termination of relationship with Women's Health Wise.
We understand circumstances may occur to cause a broken appointment. A broken appointment affect three people: the physician, another patient who is awaiting a time to be seen, and you as your healthcare needs have not been met. Cooperation is necessary on your behalf and our office staff to ensure a positive and productive relationship is maintained. We will ensure a confirmation of appointment call is made with the information provided the business day prior to your appointment.

Initial: _____

MEDICAID PATIENTS ONLY

As Women's Health Wise has a Medicaid wait list, we only accept a limited number of Medicaid patients. We have a **ZERO** tolerance policy for no call no show appointments.
Upon the 1st offense you will no longer be able to be seen at our office.
We appreciate your cooperation.

Signature of patient: _____

Release of Information

By signing below, I acknowledge primary responsibility for the payment of service to Women's Health Wise. I request my claims be filed to my insurance carrier and I authorize payment of service directly to the provider. I also permit the release of medical information to the insurance carrier or case manager when the information is requested to process claims. I do not object to this information being released by mail, fax or telephone.

I have read the Financial Policy Statement, and I understand and accept its provisions.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party

_____

Witness/ WHW Representative

MEDICARE PATIENTS ONLY

I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of authorized Medicare benefits to be made in my behalf to Women's Health Wise, LLC or individually to any physician provider of its staff for any services furnished to me by that organization or physician. I authorize the holder of the medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services

Signature of Patient: _____