FINANCIAL POLICY

Insurance Plans

Please feel free to discuss any concerns you have about this policy 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. 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 payment arrangements have been made in advance. 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 90 days will 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 90 days. In the event you default, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE of 15% 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/credit card only as an acceptable form of payment. You will also be charged a processing fee of \$35.00.		
Initial:		
No Call No Show Policy		
If at any time you are unable to attend your scheduled appointment we you do not call or come to your scheduled appointment the following p 1 st missed appointment: Courtesy call to reschedule. \$25.00 inco 3 rd missed appointment: Courtesy call to reschedule. \$50.00 inco 4 th missed appointment: Termination of relationship with Women We understand circumstances may occur to cause a broken appointment physician, another patient who is awaiting a time to be seen, and you cooperation is necessary on your behalf and our office staff to ensure We will ensure a confirmation of appointment call is made with the info appointment.	nvenience fee. nvenience fee. 's Health Wise. ent. A broken appointment affect three people: the as your healthcare needs have not been met. a positive and productive relationship is maintained.	
Initial:		
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	d 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 2 payment of authorized Medicare benefits to be made in my behalf to W physician provider of its staff for any services furnished to me by that c medical information about me to release to the Health Care Financing to determine these benefits or the benefits payable for related services	Vomen's Health Wise, LLC or individually to any organization or physician. I authorize the holder of the Administration and its agents any information needed	
Signature of Patient:		