

## Office and Financial Policies (Revised & Effective 10/1/2008)

We would like to thank you for choosing Women & Adolescents Gynecology Center (WAGC) as your medical provider. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

**Insurance:** It is **your** responsibility to contact your insurance company for verification of coverage at WAGC. WAGC is contracted with most health insurers, but each insurer has many different plans, some with restrictions.

Please ***bring your insurance card*** and ***a form of identification*** with you at the time of your appointment. For insurance plans that we contract with, your insurance carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, ***you will be asked to reschedule your appointment.***

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of the statement.

**Claim Filing:** As a courtesy, we will file your claim to your primary insurance company for you. We also submit claims to secondary insurances.

**No Insurance:** Payment of the visit required at the time of service. After your visit, the receptionist will have a balance due from you. If you are unable to pay this balance in its entirety a minimum payment of \$150.00 must be paid at time of visit. Any remaining balance will be due upon receipt of the statement. Surgical procedures will need to be prepaid.

**Coding for Services:** All health care providers bill for services using billing codes. These codes tell the insurance company what was done and why. Routine and preventive services cause confusion for many patients. It is not uncommon for patients in the course of a visit to receive both treatment for a problems and preventive service. When this occurs, we are required to charge for both services.

**Credit Policy:** Payment is due upon receipt of your first billing. If for some reason you cannot meet this requirement, please contact our business office for payment arrangements.

Patients with no insurance coverage are required to pay \$150 at the beginning of each clinic appointment and the balance will be charged and payable at the end of the visit.

Copays must be paid to the patient representative at the time of your appointment.

Our credit policy applies even while insurance coverage is pending. VISA/MasterCard/Discover/American Express is accepted for payment.

**Other Fees:** You will be responsible for all additional fees incurred by the clinic associated with your care or account.

For example:

- Non-covered or non-medically necessary lab tests that you request,
- Costs incurred for collection of ballances not resolved within 30 days

**Canceled Appointment:** If you are unable to keep your scheduled appointment, please call within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient.

**Returned Checks:** A \$30.00 charge will be added to your account for any check returned by your bank for any reason.

**Disability or Insurance Forms:** Please allow 7 to 10 days for the completion of these forms. You will be notified when the form(s) are ready for pick up.

**Medical Records:** We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7 to 10 days for us to copy these records.

I have read and understand Women & Adolescents Gynecology Center's Office and Financial Policies.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

10/01/08

**PHOTOGRAPH REFUSAL**

We will take a picture of each patient to put in our electronic EMR. If you are refusing to have this photograph taken, you will need to sign the below refusal.

Signed \_\_\_\_\_ Date \_\_\_\_\_

10/01/08

**Women & Adolescents Gynecology Center**

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

DOB \_\_\_\_\_

**Patient Financial Responsibility**

I acknowledge full financial responsibility for services rendered by Women & Adolescents Gynecology Center. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to WAGC for any medical or surgical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

I hereby give my consent to WAGC to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all protected health information contained in the patient records of \_\_\_\_\_.

For a more detailed description of this consent and other uses and disclosures, please review our Notice of Privacy Practices. Understand that WAGC reserves then right to change its privacy practices that are described above. I also understand that any Revised Notice will be available at this office or I may request a copy be sent to me by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician’s office.

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Acknowledgement – Notice of Privacy Practices**

I here by acknowledge receipt of WAGC’s Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that WAGC has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me.

Signed \_\_\_\_\_

Date \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient \_\_\_\_\_