Women's Care Florida

FINANCIAL POLICY

The doctors and staff at Women's Care Florida would like to welcome you to our Practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current—accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $25 service charge ***and*** all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- There is a $25 charge for the completion of paperwork (ex: disability, FMLA, etc.
- You may receive a statement from two different laboratories. Lab specimens are processed by the WCF laboratory and commercial laboratories. You may receive a billing statement after your Insurer has processed your insurance claim just as you would if your specimen was sent to any laboratory. These charges are separate from your office visit charges and may be subject to deductibles and/or co-insurance based on your insurance coverage and benefits. Not all recommended tests are covered by every insurance plan. Please verify coverage with your insurance plan before tests are performed
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.
- If unable to keep your appointment, please notify us in advance so that we may offer that time to another patient. A pattern of repetitive "no shows" or late cancellations may regretfully result in an assessment of a cancellation/no show fee.

If you have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, <u>not</u> your insurance company.*** Although we attempt to verify your OB/GYN benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. <u>We are here to help you.</u>

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Name (please print)	Patient Signature	Date
Responsible Party (please print) (If other than patient)	Responsible Party Signature	Date

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Visit us at <u>www.womenscarefl.com</u>