

**FINANCIAL POLICY FOR
WOMEN PARTNERS IN OB GYN**

PAYMENT UP FRONT

I understand that co-pays and services not covered by insurance are due at the time services are rendered. I understand that if I am self-pay I must pay for my visit in full at the time of service.

INSURANCE FOLLOW-UP

I understand that I am responsible for charges incurred regardless of whether my insurance pays or not.

PAST DUE BALANCES

I understand that any balance not paid upon receipt of an initial statement is considered past due. I understand that past due balances will be placed with a professional collection agency, reported to the credit bureau and that I will be responsible for collection fees, interest and attorney costs incurred. I also understand that I may not be able to schedule appointments or may be discharged from the practice.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

Co-pays: Any co-pays that are not paid on the day of the visit will be subject to a \$10.00 co-pay processing fee.

Divorce: In case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Insurance Release: This is to certify that I have been informed prior to receiving treatment that my health plan may not be liable for service rendered if any of the following conditions apply:

- * I may have a pre-existing condition or other diagnosis that may not be covered by my plan.
- * Provider not participating in my health plan.
- * Unmet deductible under my health plan contract.
- * Services may not be covered under my health plan.

Returned Checks: There is a fee (currently \$15.00) for any checks returned by the bank.

PATIENT/GUARDIAN SIGNATURE

DATE