Women's Health for Life, Inc. Financial Policy

We are committed to providing you with the best possible care. We need your acknowledgement and understanding of our offices financial policy. Please read and initial each section. We do reserve the right to refuse to treat you for unwillingness to sign our financial policy. This document is designed for full disclosure of fees that you may incur while being a patient in our office. A copy will be given to you to keep.

A- **Valid Insurance** is required to submit your claims for payment. Payment is due at the time of service if you are unable to supply us with your valid insurance card. These visits are not submitted to insurance at a later date. This includes Ohio Medicaid in most cases. You must come prepared with all insurance information. _____

B- **Co-payments** are due at the time of service. If you do not have your copayment with you at the time of service, we reserve the right to reschedule you**. We do charge an additional billing fee of $10.00** if we must bill you for your copayment. It is your responsibility to know what your copayment is if it is not listed on your insurance card. _____

C- **Deductibles/Co-insurance-** You will be billed for any amounts over and above your copayment. A reasonable payment plan will be accepted to pay off these remaining balances. Your payment plan cannot exceed 6 months unless other arrangements are made with our office. Once your account becomes delinquent, we do send it to an outside collection agency to collect payment within 90 days of your first notice of delinquency. Should collections or legal action be necessary on your account, we do reserve the right to charge you for any applicable collection fees or legal fees as a result of this process. This amount will not exceed 30% and will only be the cost of the actual fee to collect the debt.____

D- **Non-Covered Services-** We do our best to make sure you are aware if services will not be covered by your insurance, but sometimes we don't know this. While the filing of insurance claims is a courtesy to you, you are responsible for payment for services rendered to you from the date of service. Please make sure you check with your insurance before having any testing performed to be sure it is a covered benefit. We do not do retro determination of benefits. All charges are your responsibility from the date services are rendered to you. If your claim is not paid after 90 days, you will be billed and it will be your responsibility to pay. ____

E- **Yearly Exam –** Most insurance companies pay for one annual visit in a 12 month period. This includes preventative services at your family doctor as well as our office. Please let our staff know if you have had a prevention visit this calendar year to avoid duplication of services. Visits outside the frequency limitations on your plan will be your responsibility to pay _____ additionally, if you have a problem addressed at a yearly visit that is outside the scope of a preventive service, this will be billed separately to your insurance. If denied on same date of service or if a copayment applies you will be billed for this. We will provide this service the same day as a courtesy to you; however you will be responsible for payment. ____

F- **Surgeries**- Our billing department will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your responsibility to pay will be. A deposit is required prior to surgery if deductibles are not met, as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment. If your insurance company does not pay within a reasonable time, you will be billed for services. Self-pay patients must pay for the procedure, in its entirety, before it can be done. We do accept cash, check, major credit cards and care credit as forms of payment. ___

G- **Obstetrical Services**- After your first OB assessment visit, we will contact your insurance company and verify your benefits. Our fee for your maternity care will be billed to your insurance company AFTER your delivery if your plan does global (all inclusive) maternity billing. You will have an estimate for any expected out of pocket costs. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six week postpartum checkup. HOWEVER, ultrasounds, non-stress tests, lab and non-pregnancy related office visits are billed separately and will require separate copayments/deductibles. We will set you up on a payment plan for your estimated out-of-pocket expense. You can pay it all at once or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any over payment that we may receive. You MUST notify our office immediately of any changes in your insurance plan or benefits. We must have satisfactory payments on your account each month or it may impact the practice's ability to continue to provide care for you. Should your plan be a non-global plan, we will do our best to split bill your care to maximize your benefits. ___

H- **Broken Appointments**- Our office does charge for any broken appointment. A broken appointment is failure to call to cancel or reschedule at least 4 hours prior to your appointment time. This fee will range from $20.00 to $100.00 depending on the type of appointment or procedure scheduled. In the event of a third missed appointment you will be dismissed from the practice. ___

I- **Additional fees you should know** Leave of absence forms $10.00, Return Check fee of $35.00, Phone consultation without an appointment $25.00, Work or School Physicals $40.00, Tax Statement $10.00, Refill or new prescription outside of an appointment $10.00, After hours or weekend visits in office are an additional fee of $75.00, Emergency visits during office hours in the office are an additional fee of $45.00. Rebilling fee (if applicable) 3% of total patient balance on account after 90 days _____

AUTHORIZATION AND ASSIGNMENT

By signing below, I acknowledge acceptance of all of the above terms of payment as outlined in this agreement and initialed by me.

I authorize the release of any medical or other information necessary to process my medical claims as requested by my insurance. I also authorize and request that payment of benefits be made directly to Women's Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing. I have read and understand the above Financial Policy and all of my questions have been answered. I understand that changes can be made to this at any time and I will be notified. I understand that this is a legal document and can be submitted in the event of collections. I also understand that payment of all services rendered is ultimately my financial responsibility in all cases and must be paid in a timely fashion. I also understand that diagnosis codes or procedure codes cannot and will not be changed just to receive payment for services rendered. Codes will only be changed in the result of an error by the providers at Women's Health for Life, Inc. and after complete review by our coding department. By signing this authorization it is a blanket authorization for those reviews of my medical record should they be necessary.

For Questions regarding this notice, please contact:
Business Office at 419-224-0084

Patient or Responsible Party (PLEASE PRINT) Date of Birth

Signature of Patient/Responsible Party if patient a minor

Staff Reviewer Signature

Updated 02/22/2018