Women's Health
OF THE EMERALD COAST

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following office policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you regarding your complete understanding of your financial responsibilities as an element of your care and treatment.

## Financial

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. For your convenience, we accept VISA, MASTERCARD, and AMERICAN EXPRESS. Any use of a credit card will incur a convenience fee.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible, co-payments, and/or co-insurance at the time of service. This office's policy is to collect this amount when you arrive for your appointment. We do our best to evaluate your status for copay, deductible, or coinsurance prior to your visit. **It is your responsibility to know if you owe a copay, deductible or coinsurance**. Your insurance provider can assist you in this.

Patient Initial_____

- If you have insurance coverage with a plan for which **we do not have a prior agreement or is out of network**, we will prepare and send a claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service in full. If your plan requires a referral from your primary care provider **It is your responsibility** to contact that provider to have the correct referral submitted to your insurance. If we do not receive the referral one day prior to your appointment we will reschedule your appointment as we cannot provide services without it.

Patient Initial_____

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We will bill your health plan for all services provided to you in the hospital by Women's Health of the Emerald Coast Physicians or Staff. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Patient Initial_____

- If you are covered under a health plan by the **"Affordable Healthcare Act"** and you are within the 90 (ninety) day grace period for unpaid premiums, you are responsible for all medical costs not covered by your healthcare plan. You will pre pay for your visits at the time of your appointment. Once your insurance pays you will be reimbursed.

Patient Initial_____

- Our office uses three different laboratory services each bills you directly for their services. If your insurance company requires a specific laboratory it is **your responsibility to inform our clinical staff at the time of laboratory service**. We do not have access to laboratory billing information; you will need to contact them directly.

Patient Initial_____

- Your initial appointment may consist of an initial visit CPT code as well as diagnostic testing code. Many insurance companies classify these tests as a "SURGERY" but they are actually just a test done in our office. We have included the procedure codes of some possible diagnostic test done in our office so you may call your insurance company. Please know there may be additional codes not listed below. CPT: 52000, 51701, 51741, 51798, 76830, 76857

Patient Initial_____

- Annual Exam: An annual exam is defined by CMS as a well ONLY visit. If you report a problem, a problem is found on exam, or during health interview the visit will be sent to insurance as an annual exam and problem visit. Depending on your insurance this could change your financial responsibility.

Patient Initial_____

- **MEDICARE patients**: By law Medicare requires us to collect your 20% unless you have supplemental coverage.

Patient Initial_____

- **PRIVATE PAY PATIENTS:** I understand that Women's Health of the Emerald Coast is accepting me as a private pay patient. Payment is expected at the time services are rendered. If you have a question of cost at any point during or before your visit please do not hesitate to ask a staff member.

Patient Initial_____

Form Fees

Medical leave/disability/legal forms $15 per set, Medical Records $25 (for 1st 20 pages) $0.50 per page after 20 pages. Records send to a physician No charge.

Patient Initial_____

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Appointment Cancellation/Rescheduling Policy

Patients who cancel an office appointment less than 48 hours (two business days) in advance or fail to show for an appointment may be charged a fee. The following fees apply:
New Patients $100.00
Established Patients $50.00
Patients who habitually reschedule an appointment (greater than 3 times) will be charged a $25.00 fee.
This policy has been placed into effect due to increased No Shows which take time that another patient could have been cared for. If a balance on your account remains unpaid, your account may be sent to a collection agency. The patient/responsible party will then be responsible for the account balance, plus all cost of collection, including but not limited to collection fees, attorney fees, up to and including court costs.

Patient Initial_____

Assignment of Benefits

- I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorized and direct my insurance(s), including Medicare, private insurance and many other health/medical plan, to issue payment check(s) directly to Women's Health of the Emerald Coast for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

- I hereby authorize Women's Health of the Emerald Coast to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be issued to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
- I have requested medical services from Women's Health of the Emerald Coast on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
- A photocopy of the assignment is to be considered as valid as the original.

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I further understand that fees are due and payable on the date of service that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

If a balance on your account remains unpaid, your account may be sent to a collection agency. The patient/responsible party will then be responsible for the account balance, plus all cost of collection, including but not limited to collection fees, attorney fees, up to and including court cost. **I waive all rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines in the case there are any matters of financial dispute at any time after this date**. The undersigned certifies that she has read the forgoing, that any questions she had were fully explained and that she understands its contents, and herby agrees to all terms and conditions set forth in the above paragraphs set forth and acknowledges the receipt of a copy if requested.
**I have read and fully understand the Financial Policy and I agree to be bound by its terms.**

_____
Patient Name (please print)

_____ _____
Patient Signature Date

**<u>Evaluation and Treatment</u>**

- The undersigned grants authorization to the physicians, associates, and staff at Women's Health of the Emerald Coast for such treatment and procedures that may be necessary. The undersigned acknowledges that no guarantees have been made as to the results of treatments or examinations in the office or otherwise. I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

Release of Responsibility for Personal Valuables

- The undersigned understands and herby releases the physicians, associates and the staff at Women's Health of the Emerald Coast from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in her possession in the office or hospital.
- I agree that if I have any concerns as to my experience, results of procedure, or care provided at any time that **I will contact the practice directly** and agree not to post derogatory or inflammatory comments or any comments with any type of negative connotation about the practice, my physician, or my procedure of any kind on the internet or any form of social media. I give Women's Health of the Emerald Coast and my provider full authorization to have any comments they deem to be negative in any way removed from the internet or any other form of social media without notification.

The undersigned certifies that she has read the forgoing, that it has been fully explained and that she understands its contents, and herby agrees to all terms and conditions set forth in the above paragraphs set forth and acknowledges the receipt of a copy if requested.

_____ _____
Patient/Patient Representative Signature Date

_____
Witness Signature