

COMPREHENSIVE WOMEN'S HEALTHCARE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payment for services **not covered by your insurance plan** is due at the time of service. Payment for services **denied by your insurance plan** are due immediately upon receipt of a statement from our office. We accept checks, cash, money orders, debit cards, MasterCard and Visa. We will be happy to file your insurance if we are listed as a "Participating Provider" on your plan. You must realize, however, that:

- Your insurance is a contract between you, the employer and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- We will file your insurance on plans we participate with only if we have a current copy of your insurance card and all pertinent information required for filing claims (insured's social security number, date of birth, etc.).
- If we are unable to verify benefits for a same-day procedure, you will be asked to self-pay or reschedule. If you choose to self-pay, we will file for the procedure and upon receipt of the insurance explanation of benefits, refund you if a credit balance exists.
- Not all services are a covered benefit under your insurance contract. Some insurance companies arbitrarily select certain services they will not cover or they may set maximum limitations. Any services identified as such are your responsibility and payment will be due at the time of service.
- If your plan requires a referral from a PCP (Primary Care Physician) before seeing a specialist, it is your responsibility to obtain that authorization prior to being seen in our office.

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the service is rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us immediately for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

I hereby authorize Comprehensive Women's Healthcare, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Comprehensive Women's Healthcare will file my insurance on my behalf and that I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full for all balances due that are not paid for by the insurance company.

Date _____

Signature of Patient or Personal Representative

****I have been advised of, and been shown this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document, if I choose.

Date _____

Signature of Patient or Personal Representative

