THE FEMALE PELVIC HEALTH CENTER

FINANCIAL POLICY

Thank you for choosing The Female Pelvic Health Center as your healthcare provider. Please take a moment to read our financial policy.

While we participate in many health plans, there are some in which we are non- participating. Please be aware that most health plans do include out-of-network benefits that will cover a significant portion of the services rendered. If we do not participate in your plan, a representative from our billing department will be glad to review your financial responsibility.

Please be advised your new patient appointment will be a minimum of an hour

Insurance Policy

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. You are ultimately responsible for payment to our doctors for provided services.

We will gladly process your claim, but we request your estimated portion to be paid in full at the time of service. If your insurance company has not paid your account in full within 60 days, you will have 30 days to arrange payment of the balance due.

If you are a member of a managed care plan in which we are a participating provider, please understand we require payment of co-pays and deductibles at the time of service.

Referrals

If your health plan requires a referral, we cannot provide services to you without it. It is **YOUR RESPONSIBILITY** to contact your primary care physician and request a referral. Your primary care physician may be able to forward the referral to us electronically.

IF WE HAVE NOT RECEIVED YOUR REFERRAL BY NOON THE DAY BEFORE YOUR APPOINTMENT, THE APPOINTMENT WILL BE RESCHEDULED.

Appointment Cancellation Policy

If you are unable to keep your appointment, kindly give us 24 business hours notice. Your appointment time can then be made available to a patient on our waitlist. If notice of cancellation is not received, you will be charged as follows:

New patient/procedures: $50 Established patient visit: $25

***If you have cancelled the same appointment twice or miss two appointments without 24-hour notice, you will no longer be able to schedule appointments with our practice.**

*** If you DO NOT SHOW for your New Patient Appointment, Your appointment will NOT be Rescheduled and you will not be able to be seen in our office due to the limited availability of these appointments.**

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Medicare Authorization and Assignment

We do accept assignment of benefits; however, we are legally required to collect your deductible and 20% coinsurance at the time of service unless you have a supplemental insurance.

I request that payment of authorized Medicare benefits be made on my behalf to the service provider for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it s agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employers' coverage or Medigap insurance. I hereby authorize that photocopies of the form be treated as originals.

Patient Signature: _____

Commercial Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to the service provider for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employers' coverage or Medigap insurance. I hereby authorize the service provider to release any medical information necessary to process my claim. I hereby authorize that photocopies of the form be treated as originals.

Patient Signature: _____

PLEASE SIGN BELOW ACKNOWLEDGING THAT YOU FULLY UNDERSTAND OUR FINANCIAL POLICY.

We accept Cash, Check, or Credit Card (Visa or Mastercard)
There will be a $35 fee for any bounced check

Patient Signature: _____

Revised 08/17/16