

ASSOCIATES FOR WOMEN'S HEALTH
 533 E County Line Rd., Suite 102, Greenwood, Indiana 46143
 Main Phone (317) 859-6626***Billing Dept. (317) 887-4684***Fax (317) 887-4691

OUR FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is a part of this care. Your clear understanding of our financial policy is important to our professional relationship. Please ask our staff if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete (in full) our "Patient Information Form" and provide us with accurate insurance information including an insurance card at each visit before seeing the provider.
- Full payment is due at the time of service; we accept cash, checks, Visa and MasterCard.

RESPONSIBLE PARTY

You will be responsible for your changes regardless of any divorce decree or court order regarding payment of medical bills.

MINOR ACCOMPANIED BY AN ADULT

A parent or legal guardian must accompany patients who are minors on the patient's visit, and must sign the financial statement for the patient, accepting responsibility for the account.

<i>If you have...</i>	<i>You are responsible for...</i>
HMO, PPO, and POS plans with which we have a contract	<p><i><u>If the services you receive are covered by the plan:</u></i> All applicable co-pays and deductibles are expected at the time of the office visit.</p> <p><i><u>If the services you receive are not covered by the plan:</u></i> Payment in full is expected at the time of the visit.</p> <p>We suggest that you call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services. It is your responsibility to obtain all necessary referrals.</p> <p><i><u>We will file an insurance claim as a courtesy to you.</u></i></p>
Medicare	<p>If you have Regular Medicare, and have not met your \$100 deductible, we expect it to be paid at the time of the service.</p> <p>Any services not covered by Medicare will be your responsibility.</p> <p><i><u>If you have Medicare as primary and also have secondary insurance (Medigap):</u></i> No payment is necessary at the time of the visit.</p> <p><i><u>If you have Medicare as primary, but no secondary insurance:</u></i> Payment of your 20% co-pay is expected at the time of the visit.</p> <p><i><u>We will file an insurance claim as a courtesy to you.</u></i></p>
No Insurance / Self-Pay Commercial Insurance	<p>Payment in full at the time of the visit. If the total cost of the visit is not able to be determined, you will be asked to make an estimated payment and will be billed or credited for the difference. Please ask to speak with our staff if you need assistance on an extended payment schedule.</p>

NON-SUFFICIENT FUNDS CHECK

Your account will be charged \$25.00 for each time a check is returned for non-sufficient funds. If your bank does not honor these checks, you will be responsible for the payment of the check and additional charges within 10 days. If payment is not made, a claim will be filed in court for three times the amount of the check, NSF charge, court costs and any past due balance. Any future payments due to your account will need to be made with cash or credit card.

COLLECTION POLICIES: Payment from statement is due upon receipt. If your account has not been satisfied within a reasonable period of time, this may result in preparation of account for small claims court, collection agency and/or credit bureau reporting and discharge from the practice. In the event an account is turned over for collection, the person financially responsible for the account will be responsible to pay for all collection costs; including court costs allowed by law, cost of collection and reasonable attorney fees. A patient may remit in full for all outstanding charges owed on account and include amounts previously placed with the collection agency. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us service you better by keeping your scheduled appointments.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Associates for Women's Health, PC and I authorize them to release any pertinent medical information to facilitate payment of the claim.

I have received a copy of this policy.

 Responsible Party Signature

 Date