CONTEMPORARY women's HEALTH™

FINANCIAL POLICY

10031 Sherrill Blvd | Knoxville | TN 37932 | p: 865.540.1650 | f: 865.246.4755

Patient's Name: _____ DOB: _____

Thank you for choosing Contemporary Women's Health, PLLC as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and todays' date.

_____ (initial) INSURANCE: It is the patient's responsibility to provide the office with current insurance information. **Please have your insurance card every time you come to the office.** You are responsible for notifying us of any changes in your insurance coverage. If you fail to do so in a timely manner, you will be responsible for the balance.

_____ (initial) Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copayments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

_____ (initial) CO-PAYS: Co-payments are due at the time you check in at the front desk **PRIOR** to being seen by the Physician or Physician Extender. You will also be asked to make a payment on any balance you may have from previous services.

_____ (initial) OB PATIENT: **(with Insurance)** Our OB charge is a package that includes up to **14** routine prenatal visits, **3** ultrasounds, delivery and post-partum visit. Our office will pre-certify your pregnancy and complete any necessary paperwork required by your insurance company. We will also obtain your OB benefit coverage, which will include deductible and co-pay information (for physician charges only). If you are responsible for deductible and/or copays, these amounts will be collected prior to the delivery. If you cannot pay the amount in full, payment arrangements can be discussed with the business office. We will discuss with you our "OB Budget" plan after the information has been confirmed by your insurance carrier. After delivery, once we have received payment from your insurance company and if additional payment is required from you, we will send you a statement. You will receive statements periodically throughout your pregnancy for amounts not covered by your insurance and not included in the OB package charge. The balance will be due upon receipt.

_____ (initial) OB PATIENT: **(without Insurance)** Our OB charge is a package that includes up to **14** routine prenatal visits, **3** ultrasounds, delivery and post-partum visit. The package price for routine vaginal delivery is **$2200,00.** If a cesarean is planned this charge will be adjusted. This amount is for physician charges only and does not include any laboratory, sonograms, problem office visits. These additional charges should be paid as they occur. Uninsured OB patients will be responsible for half, or $1,100 at the time of their first visit. The remaining balance of $1,100 must be paid by the end of the following month. Patients will be billed after their delivery for any additional balance.

_____ (initial) GYN PATIENT: **(without Insurance)** An **ESTIMATED** payment is due at the **time of service** and will be collected prior to being seen. You are responsible for any remaining balance. If pap is done, the lab will accept reduced payment if paid at time of service. If pap is abnormal additional testing may be necessary. In that case, you may call American Esoteric Laboratories and they will reduce the payment required for those additional services.

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_____ (initial) UN-PAID BALANCES: If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. You are responsible for payment in full upon receipt of statement. We accept cash, checks, money order, Visa, MasterCard, Discover, Amex, and CareCredit. If legal action is necessary to collect unpaid balances, all fees associated with that process will be added to the patient's account balance.

_____ (initial) NON-PAYMENT: It is our policy that patients be sent **3** statements. Any balance afterwards will incur a **late fee** as follows:

$10.00(Balances $20.00-$99.99) **$25.00**(Balances $100.00-$249.99)
$50.00(Balances $250.00-$499.99) **$75.00**(All Balances over $500.00)

_____ (initial) ANY OVERDUE BALANCES: May be considered for further collection activity. If your account is turned over to collections, you will be dismissed, and a **30%** collection fee will be added to your account balance. If legal action is necessary to collect, all fees associated will be your responsibility.

_____ (initial) RETURNED CHECKS: The charge for a returned check is **$25** payable by cash, money order or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a "Cash Only" basis following any returned check.

_____ (initial) MINORS: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

_____ (initial) MEDICAL RECORD/ FMLA AND/OR SHORT-TERM DISABILITY: If you want a copy of your records, you will be charged a **$20** copying fee. We will forward your records free of charge to another physician with a signed medical records release. There is also a fee of **$10.00-25.00** for completion of FMLA and/or short-term disability paperwork depending on form complexity. All fees are due at time paperwork is received from patient. Please allow **7-10** days for completion of forms.

_____ (initial) PRESCRIPTION PRIOR AUTHORIZATION: There will be a charge of **$10.00 -$20.00** (depending on complexity) for any medication prior authorization we are required by your insurance company to obtain. This charge is payable in advance of authorization being obtained.

Thank you for understanding our Financial Policy. We strive to provide the highest quality of care and attention to each of our patients. Your assistance and cooperation are most appreciated. Should you have any questions or concerns please notify us.

I have read and agree with Contemporary Women's Health's Financial Policy,

Patient Signature: _____ Date: _____