## FINANCIAL POLICY

1. All charges, regardless of the insurance coverage, are the patient's responsibility. Patients are responsible for knowing what services are covered under their insurance plan. Women's Health Associates must bill the visit according to the services provided.
2. Patients will be asked to provide their current insurance card and mailing address at the time of service. It is the patient's responsibility to inform our office of any insurance, address or telephone number changes.
3. Full payment of the patient's estimated portion is expected at the time of service. This includes copays, deductibles and co-insurance. Patients are responsible for paying the part of the bill that is not covered by their insurance company.
4. Once insurance has processed, patients will receive monthly statements asking to clear the balance of their account. If payment arrangements are necessary, it is your responsibility to contact our billing department to establish a reasonable plan.
5. After 90 days, any unpaid balance will begin to accrue interest at the rate of 1% per month (12% annually) or a minimum of $1.00 per statement cycle.
6. Sixty days following the initial statement, if account remains delinquent, it will be referred to our in-house collections.
7. Lack of action from the patient will result in the account being sent to an outside collections agency and termination of care from our office.
8. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Women's Health Associates. This assignment will remain in effect unless revoked in writing.

I have read and understand the Financial Policy and agree to meet all financial obligations.

______________________________________________________________________

**Signature of Patient or Responsible Party** **Date**

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## RECEIPT OF PRIVACY PRACTICES

I have been presented with the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I acknowledge the receipt of Women's Health Associates Notice of Privacy Practices.

______________________________________________________________________

**Signature of Patient or Responsible Party** **Date**

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## CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I ______________________________________________ authorize Women's Health Associates to view my external prescription history from the Multum and Medi-Span database.

I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by Women's Health Associates providers and staff, and the information may include prescription I had filled over the past several years.

My signature below certifies that I have read and understand the scope of my consent and that I authorize the access.

______________________________________________________________________

**Signature of Patient or Responsible Party** **Date**