WOMEN`S PHYSICIAN, LLC

At ***Women`s Physician, LLC***, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the process or reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours. If you have had any changes in your insurance coverage, you must notify us.

CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment for each and every date of service. You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We may not have information about each person's deductible amount, or how much of it has been met. You will be responsible for finding out all information regarding your deductible prior to your appointment with our office.

SELF PAYMENT / SELF-PAY

All cash patients and patients present without valid insurance information are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel at the end of your visit. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at time of service until your insurance information is on file.

NO SHOW FEE

All patients are responsible to call the office if you can not make it to your appointment at least 24 hours in advance, failure to do so will results in a $25 no show fee.

Print name: _____

Signature: _____

Date: _____