Ladies First Health Care

"Where Your Health Comes First"

Patient Financial Policy

It is a goal of Ladies First Health Care to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to fully understand our patient, insurance, credit, and collections policies. **We ask that you initial next to each number and sign this statement once you have carefully read the following information.**

Thank you for your cooperation!

_____ 1. **Payment Responsibility:** The patient or legal guardian is responsible for all charges that are incurred. Payment is expected promptly following receipt of monthly statement.

_____ 2. **Insurance Contract:** Your insurance contract is an agreement between you and your insurance carrier. As a courtesy to you, our office is able to file your insurance claims for you. Your doctor's bill is an agreement between you and this office. You are ultimately responsible for payment of your bill regardless of the status of your insurance claim.

_____ 3. **Insurance Verification:** Your insurance is verified prior to your appointment. If the policy is inactive, the patient is responsible for all charges incurred. All information is subject to verification.

_____ 4. **Partial Insurance Coverage:** If your insurance only covers a portion of a service, you are responsible for the difference.

_____ 5. **Assignment of Benefits:** Our office will bill your insurance if you supply all necessary information such as proof of identification and insurance cards. It is the patient's responsibility to know what their insurance benefits cover. If you have an HMO insurance we can assist you in acquiring a referral from your Primary Care Physician. If they refuse to issue one, or the referral is not finalized by your appointment date, you will not be seen.

_____ 6. **Discounts:** By Federal Law and Managed Care Contract Laws, we are required to collect all co-pays and deductibles for each service. Therefore accounts cannot be reduced or discounted.

_____ 7. **Refunds:** Overpayments will be refunded once all active and past dues accounts are paid in full. Refunds of less than $5.00 will not be processed unless specifically requested.

_____ 8. **Outstanding Balances:** Patients with outstanding balances will be required to pay on their account PRIOR to being seen. Patients with a balance exceeding $200.00 will not be permitted to schedule future appointments until the balance has been paid to below $200.00.

_____ 9. **Delinquent Accounts:** Patients that have unpaid delinquent accounts and/or accounts that have been sent to collections may be discharged for financial negligence at the discretion of office management.

_____ 10. **Referral for Outside Collection:** If we do not receive payment in full by 90 days from the date of service or you do not maintain a payment arrangement as outlined by a staff member and signed by you, we reserve the right to refer your account to an outside collections agency for a fee of $100.00, at which point you will be responsible for all collection and attorney fees.

_____ 11. **Missed Appointments:** If you miss an appointment or fail to give 24 hours' notice, your account will be charged $20.00 for each appointment.

_____ 12. **Returned Check:** A fee of $25.00 will be assessed to your account each time a check is returned.

_____ 13. **Payment Methods:** We accept cash, check, and money orders. Any payments made by credit/debit card via phone or mail will be charged a $2.00 processing fee. After your card information is used for payment processing it is destroyed and NEVER given out to third parties.

_____ 14. **Lab Billing:** All lab work billing issues must be initially addressed with Quest Diagnostics. If you require lab work to go to a different lab than Quest Diagnostics you must let the staff know prior to having blood drawn, a Pap smear, culture collection or biopsy completed, if you do not inform a staff member and your labs are sent to Quest Diagnostics, YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED!

I have read and I understand the above financial policy.

_____ _____

Signature of Patient or Representative **Date**