

Physician's for Women's Health
Women's Obstetrics and Gynecology, P.C.
115 Technology Drive, Suite A200
Trumbull, CT 06611
Telephone (203) 268-2239 Fax (203) 268-9143

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

Non-Emergency Appointments:

Gyn exams, physicals, and any non-emergent follow-ups may be rescheduled if there are outstanding balances or co-pay is not paid at time of service. Health insurance is a contract between you, your employer, and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy, visits, referral and authorization requirements, x-rays, ultrasounds, lab tests, etc .. If you are experiencing financial difficulty, please let us know.

Billing and Collections:

- With more healthcare costs paid directly by patients, we have had to adjust our business procedures. As a result, you are required to pay balances that are not covered by your insurance company.
- Dependent(s) on parent's policy up to the age of 26 years old, the parent (Subscriber of the policy) is responsible for full payment at the time of service and all outstanding balances.
- A \$30 fee will be charged for all returned checks and your account will be placed on a "cash or credit card basis only."
- A \$10 fee will be charged for certified mail sent to you for follow-up appointments or any other communications.
- The credit card on file/system will not be used for any purpose other than outstanding balances (co-pays, deductibles, co-insurance, non-covered charges and rejected claims. A statement of balances charged to your on file credit card will be provided upon request. Please check you insurance Explanation of Benefits (EOB) for details.
- **Missed appointments and late cancellations** will be charged a \$150 fee. Cancellations are requested 24 hours in advance prior to appointment. After a second missed appointment, we may discharge you from the practice.
- Balances will be billed to the patient and outstanding balances are due within 30 days from date of service/visit. Payment plans can be offered to pay in full amount within 6 months of date of service with 18% annual interest charge.

Participation with Insurance Companies:

- All services will be submitted as a courtesy to your insurance. If the insurance does not cover services (including rejection due to invalid information, cancelled policy, non-network provider, non-covered procedures etc.) that were performed, any balance will become the patient's responsibility.
- If we don't participate with your insurance company, payment is due at the time of service. We can print out an itemized bill for you to give to your insurance company for a possible reimbursement.
- We suggest you contact your health insurance plan in advance of your appointment to discuss coverage and reimbursement. It is important for you to understand your benefits as they relate to services your physician may provide or prescribe.

Patient Initial: _____

Date: _____

Parent's name and address (for Dependent Policy holder):

Name: _____

Address: _____

DOB and Phone # _____

Physician's for Women's Health
Women's Obstetrics & Gynecology
115 Technology Drive, Suite A200, Trumbull CT 06611
140 Sherman St. Fairfield, CT 06824
Telephone (203) 268-2239 Fax (203) 268-9143

The following credit card will be kept on file with Women's Obstetrics and Gynecology, P.C. and will not be used for any purpose other than outstanding balances, i.e.- co-payments, coinsurance, deductibles, and charges not covered by insurance, only after statements have been mailed to you with the amount due. If, however, your account is more than 30 days from the date of services, we will use this card to bring your account current.

Additional Credit Card Information:

Type: ___ Visa ___ MC ___ Discover ___ American Express

Card Number: _____ Expiration Date: _____

Name as it appears on card: _____ 3 Digit Code: _____

Signature: _____ Date: _____

HSA Card Information:

Type: _____ Visa: _____ MC: _____ Discover: _____ AMEX: _____

Card Number: _____ Expiration Date: _____

Name as it appears on card: _____ 3 Digit Code: _____

Signature: _____ Date: _____