Physicians for Women's Health

An Affiliate of Women's Health Connecticut

Effective 07/01/2021

Patient Financial Agreement

Please read the below terms and conditions in this Patient Financial Agreement ("Agreement") carefully as it is our intent with this policy to outline patient and practice financial responsibilities and obligations fairly and clearly. You will be asked to sign this document. This Agreement will remain in full force and effect unless modified by Physicians for Women&apso;s Health, LLC, its successors, and assigns.

- It is your responsibility to provide us with current insurance and demographic information and to bring your insurance card to each visit. Reasonable efforts will be made to confirm your insurance eligibility prior to any scheduled visit and/or procedure. If it is deemed that you do not have any insurance, you may be asked to pay for all or a portion of the cost of your care at the time of service. Eligibility does not guarantee coverage. It is your responsibility to understand your covered benefits and out-of-pocket costs for copayment, deductibles, co-insurance, and non-covered services. These balances may be required to be collected prior to or at the time of service. It is your responsibility to ensure that any insurance required referrals for treatment are obtained and provided to the practice prior to the scheduled visit. Failure to obtain a required referral may require rescheduling the visit or you may be held financially responsible for payment.

- We will submit a claim to your insurance carrier on your behalf. Once the claim is processed, a final determination will be made as to any remaining amount that you owe to Physicians for Women's Health, LLC. If we do not participate with your insurance company, your upcoming visit/procedure will likely be deemed to be out of network. As a result, your insurance company may not pay for the services provided or may pay only a limited out-of-network amount towards your care as detailed in your policy. Full or partial payment may be collected at the time of service. Any balance up to and remaining after 30 days, including any applicable co-insurance, co-pay or deductible amounts will be your responsibility.

- If you fail to provide valid insurance information within your current health plan's filing limit for services rendered, you will be financially responsible for all unpaid claims.

- During the course of your scheduled exam or procedure, additional services for laboratory, imaging or unscheduled problems may be needed. Additional claims for these services will be submitted to your insurance carrier. You may receive separate statements for any balances for these billed services.

- You may choose to not bill your insurance carrier for specific services. It is required that payment is made in full at the time of service.

- This office may have a no-show policy which charges a no-show or late cancellation fee if not given 24 hours advanced notice. Insurance carriers will not cover this fee and you will be responsible for this balance.

- Patient account balances that remain outstanding after reasonable collection efforts have been made will be referred to an outside collection agency. You agree to pay all reasonable costs of collection of your account balance to the extent permitted by law, including but not limited to: (i) out-of-pocket expenses; (ii) administrative and record-keeping costs; (iii) reasonable attorneys' fees; (iv) and all service charges and costs of the collection agent designated by Physicians for Women's Health, LLC including, but not limited to, any fee based on the account balance of the account referred to or recovered by the collection agent. A collection fee of no more than 15% of the account balance may be charged to you.

- If you refuse to authorize release of medical information to support claims billed to your insurance carrier and this results in a refusal by your carrier or other responsible payer to pay, you will be financially responsible for all unpaid claims.

- I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for all amounts owed by me. I agree to the terms set forth in this Agreement and to pay additional costs, including attorney's fees, associated with the collection of any amounts due for services rendered as set forth above.

- I hereby authorize Physicians for Women's Health, LLC., their respective agents and business associates to contact me at any current or future telephone numbers, including wireless telephone numbers or devices which could result in charges to me. I understand that this contact may include the use of pre-recorded or artificial voice messages, text messages and may also include the use of an automatic telephone dialing system.

*Patient Signature (or person authorized to sign for patient)*____________________________________ *Date*________

*If authorized signer, relationship to patient*____ *Date*________

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Assignment of Benefits and Release of Information

I certify that the insurance information I have provided is correct and accurate and hereby authorized Physicians for Women's Health, LLC to submit claims to Medicare, Medigap, and commercial insurance payers on my behalf. I assign any payment and/or benefit from these payers for these services to Physicians for Women's Health, LLC. I further authorize the release of any medical records necessary and allowed by Federal or State law without specific authorization for the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered.

Your initials are required to release the following information to your health insurance plan if requested for payment:

___________________HIV/AIDS Test Results/Treatment

___________________STD Records

*Patient Signature (or person authorized to sign for patient)*_____________________________________ *Date*________

*If authorized signer, relationship to patient*____ *Date*________