

# Financial Policy for North Florida Women's Care

I, \_\_\_\_\_, understand this financial agreement outlines my obligations to North Florida Women's Care (the "Clinic") with regard to payment for services rendered.

- The Clinic is a contract provider with many health insurance companies, health maintenance organizations, and managed care programs ("HealthCare Plans"). Our billing office will submit a claim for any services rendered to a patient who is a member of one of these contracted plans. Patients must provide all necessary insurance information and complete all required forms prior to or at the time of service. It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. If one or more services is not covered by a patient's HealthCare Plan, then at the time of service(s) the patient shall make payment in full for such service(s), unless the Clinic agrees in writing to other payment arrangements.
- If a patient is a member of a HealthCare Plan with which we do not have a contract, then the patient agrees to pay the full amount of the Clinic's charges for health care services rendered. Payment shall be made in full at the time of service, unless the Clinic agrees in writing to other payment arrangements. The Clinic may, but is not obligated to, file claims with the HealthCare Plan. However, such HealthCare Plans usually send payment to the patient and not to the Clinic.
- If a patient is not covered by any HealthCare Plan, then the patient shall pay the full amount of the Clinic's charges for health care services rendered. Payment shall be made in full at the time of service, unless the Clinic agrees in writing to other payment arrangements.
- Payment for professional services may be made by cash, check or credit card. We accept VISA®, MasterCard® and Discover®.
- The Clinic may charge a fee, up to the maximum amount permitted by Florida law, for each returned check.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided **prior to the visit**. In the absence of a required authorization or referral, the patient's visit may be rescheduled.
- It is the patient's responsibility to understand the HealthCare Plan benefits. Our staff is happy to help with insurance questions relating to a claim that has been filed, or to provide additional information which the HealthCare Plan may need to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of the HealthCare Plan's member services department. The phone number for member services is usually on the insurance card.
- When requesting the completion of disability forms, the Clinic reserves the right to charge a fee of up to \$25 per form.
- Please understand that a patient's failure to cancel an appointment which she is unable to keep may prevent other patients from receiving medical care they need. Therefore, the Clinic reserves the right to charge a fee of up to \$50 for appointments that are not cancelled at least 24 hours in advance. Any patient who fails to keep three or more appointments in a twelve-month period without prior notice of cancellation may be discharged as a patient of the Clinic.
- If a patient fails to make payment in full to the Clinic, then the patient agrees to pay all reasonable costs which the Clinic incurs to collect the debt, including without limitation: (a) the reasonable fees of collection agencies and (b) the reasonable attorneys' fees and court costs incurred by the Clinic. The venue for any litigation shall be in Leon County, Florida, notwithstanding the fact that the patient may at any time reside outside Leon County, Florida.

## Agreement

I agree to make all payments and to comply with all other terms of this Financial Policy:

Patient's Signature \_\_\_\_\_

Print Name: \_\_\_\_\_

Date \_\_\_\_\_

If the patient is under age 18 or if the patient is unable to sign this form, then the undersigned agrees to make all payments and to comply with all other terms of this Financial Policy.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## Assignment of Benefits

I hereby assign to North Florida Women's Care any and all benefits payable by my Health Care Plan(s) for services rendered by North Florida Women's Care. I instruct my Health Care Plan to pay all such benefits directly to North Florida Women's Care. I hereby authorize North Florida Women's Care to release all medical information requested by my Health Care Plan(s) in connection with this Assignment of Benefits.

If the patient is under age 18 or if the patient is unable to sign this form, then the undersigned agrees to the Assignment of Benefits set forth above.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_