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Financial Policy for North Florida Women's Care

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

*NFLWC 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, co-insurance and/or deductible due. If one or more service(s) 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 NFLWC 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 NFLWC's charges for health care services rendered. Payment shall be made in full at the time of service, unless NFLWC agrees in writing to other payment arrangements. NFLWC 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 NFLWC.

*If a service is not covered by any HealthCare Plan, then the patient shall pay the full amount of the NFLWC's charges for health care services rendered. Payment shall be made in full at the time of service.

*Payment for professional services may be made by cash, check or credit card. We accept VISA, MasterCard, Discover and American Express. Payment can also be made electronically through the patient portal.

*NFLWC may reschedule the patient's appointment when payment is not available.

*NFLWC 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 and/or insurance forms, sharecare will charge \$30 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, NFLWC 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 NFLWC.

*If a patient fails to make payment in full to NFLWC, then the patient agrees to pay all reasonable additional costs which NFLWC incurs to collect the debt, including without limitation: (a) 25% of the principal balance charged as collection agency fees and (b) the reasonable attorneys' fees and court costs incurred by NFLWC in such collection efforts. 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. Future appointments will not be scheduled unless patient balance is paid in full.

*NFLWC sends statements electronically and securely to the email account on file. If the patient wishes to OPT out, the patient needs to notify NFLWC staff either verbally or in writing.

Agreement

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

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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.

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Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____