WomanCare, Inc**.**

PATIENT FINANCIAL POLICY

WomanCare, Inc believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a form of identification due to many cases of identity theft.

2. INSURANCE: We are participating providers with most insurance plans. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from the insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejected for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. RETURNED CHECKS will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the$30 service fee and collections action. All bad checks written to this office are subject to collections.

4. ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. FORM FEES: completing insurance forms, copying medical records, etc… Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence. Copying fees for Medical Records is $10 and additional $0.50 per page. WomanCare, Inc. will have 15 business days in which to copy records before making them available for patient pick up, payment is required before the records will be released and after patient has signed a form authorizing records' release.

6. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **WOMANCARE, INC.** for charges not covered by the assignment of insurance benefits.

7. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **WOMANCARE, INC.** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize WomanCare, Inc. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to WomanCare, Inc. I authorize WomanCare, Inc. to release all medical information (including, but not limited to, information

on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. INSURANCES WE WON'T BILL: We do not bill out-of-state Medicaid plans. The patient will be responsible for the services in full.

9. RELEASE OF INFORMATION: I hereby authorize and direct **WomanCare, Inc.** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

10. MINOR PATIENTS: The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgement must be determined between the individuals involved, without the inclusion of WomanCare, Inc.

11. DIVORCED PARENTS of PATIENT: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate which each other about the treatment and payment issues.

12. INSUFFICENT INFORMATION: I understand if I do not provide sufficient demographic and billing information to WomanCare, Inc., which results in a bad address, etc… and I am unable to be contacted through verbal or written communication, my account may be sent to a collection agency and result in possible discharge from the practice. I understand that I may not be able to schedule an appointment until this has been paid in full.

13. STATEMENT PROCESS: Payment is due upon receipt of statement of first statement. If not paid you will receive a Past Due and then Final Notice. If the balance has not been paid within this time frame, the account may be sent to collections with additional fees added to account (see below).

14. COLLECTION FEES: I understand that in the event my account is place in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees and collection agency fees. I understand that these additional fees will be my personal responsibility to pay in full.

15. NO-SHOW FEE: If you do not show for your appointment, we will assess you a $15.00 missed appointment fee.

BILLING OFFICE: If you have any questions in regard to any of your billing statements, our accounts receivable staff at WomanCare, Inc. is available to assist you. **CALL 304-366-6100.**

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of Patient (or parent/guardian, if applicable) Date

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Print name of parent/guardian (if applicable) Print patient name