ASSOCIATES IN WOMEN'S HEALTHCARE
FINANCIAL INFORMATION and AGREEMENT FOR PAYMENT

Welcome and thank you for choosing Associates In Women's Healthcare (AWH). We hope you will find our staff friendly and helpful. It is our goal to provide exceptional medical care, as well as, making our medical billing process as simple and efficient as possible.

The cost of medical care is determined by the nature and degree of difficulty of the visit. Due to the complexities of medical insurance, it is impossible for us to know the specific benefits of the ever-changing insurance plans. Please review the information below so we can avoid billing issues and miscommunications. The medical benefits authorization and agreement for payment must be signed prior to seeing the provider.

1. INSURANCE: Please bring your **current insurance card** to each visit. If at any time your insurance should change, especially during pregnancy, please notify our office immediately AWH will file insurance claims and assist with appeals to primary insurance carriers for up to 90 days from the date of service. As soon as your claim processes and posts in our system, the remaining balance will become the patient's responsibility and is due immediately.

2. CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED FEES: Co-payment, insurance deductibles and non-covered fees are due at the time of service. Payment plans are available if arrangements are made in advance. SELF PAY: Patients who do not have or elect not to use insurance benefits will receive a 20% discount if full payment is made at the time of service.

3. CREDIT CARD ON FILE: We require that patients place a credit card on file to be used to cover any balance remaining after the primary insurance company has adjudicated your claim.

4. BILLING AND INSURANCE QUESTIONS: To ensure clear communication and provide a tracking mechanism, please submit billing and insurance questions through the patient portal. It is our goal to research and respond within 2 business days.

5. APPOINTMENTS: **We request that all forms and medical questionnaires are completed on-line prior to arrival.** This will expedite check-in, clinical work up and reduce wait time**.** If you are unable to complete the forms online in advance, please arrive at our front desk at least 15 minutes prior to your appointment time. Failure to do so may result in rescheduling and an inappropriate cancellation fee.

6. NO SHOWS and INAPPROPRIATE CANCELLATIONS: If you are unable to keep your appointment, please provide at least 24 hours advance notice in order to avoid a fee. Surgery and procedure require a two-week notice.

7. MAIL ORDER MEDICATIONS: You are responsible for obtaining any necessary insurance prior authorization requirements for your medications. We are glad to assist but, you must provide the appropriate forms at the time of your visit. We reserve the right to charge a

$25 service fee for redundant or complicated prior authorizations and excessive movement of prescriptions from one pharmacy to another.

8. AFTER HOURS CONSULTATIONS and Rx REFILLS: For non-emergent issues we ask that you contact us during regular office hours, otherwise, a service charge may be billed to you. Please call your pharmacy first for prescription refills. The pharmacy will send us an electronic request.

9. PREVENTATIVE VISITS: Our physicians follow ACOG guidelines and provide services which meet the quality measures imposed by accreditation agencies and insurance carriers. Coverage varies by insurance carrier. Please be aware that additional services requested at the time of the Preventative Care/Wellness Visit are often subject to insurance co-payment, deductibles and co-insurance

10. SCREENING TESTS AND LABWORK: Screening Tests and Lab Work are recommended according to individual needs and to satisfy insurance carriers, quality measures, federal mandates, and accreditation agencies. Specimen handling will be filed by our office but, the reference lab will file with your insurance for their services and bill you for balances that insurance does not cover. If you receive a bill for lab work and have questions, contact the reference lab indicated on your invoice. We will be glad to provide additional assistance if necessary. Please be aware that some policies do not consider lab work and screenings tests as preventative care so deductibles and co-insurance will apply.

11. OUTSTANDING BALANCES: After your insurance claim processes, AWH will send an electronic notice advising of the balance due and that your credit card will be charged in 5 days. If you wish to make another form of payment, please contact our office immediately if you wish to make another form of payment.

12. DELINQUENT ACCOUNTS: AWH will make two attempts to collect outstanding balances. If you have not paid in full or arranged and honored a payment plan, we will refer your account to a collection agency or our attorney. They in turn will report your past due status to a Credit Reporting Agency. Any fees incurred by AWH from the Collection Agency, Attorney or Court costs will be added to your account and become your responsibility. Additional Services will not be provided until the account is settled.

13. RETURNED CHECK and FAILED CREDIT CARD: There is a $35 fee for returned checks and failed credit cards.

14. COMPLETION OF FORMS AND LETTERS: There is a $25 fee for the completion of forms and/or letters requested by the patient or the patient's employer or insurance company. These forms include, but are not limited to: Disability, FMLA, Leave of Absence, Letters regarding travel, employment, prescriptions, etc. Please be sure to complete and sign any patient sections of the form prior to submission and allow 7-10 business days for completion.

15. MEDICAL RECORDS: Patients may print visit summaries and lab results from the MY HEALTH section of the patient portal. If a complete copy of the medical record is necessary, it may be obtained by submitting the written release authorization which may

be found on the patient information page on the AWH website. Fees for this service are dictated by: ***North Carolina General Statutes §90-411*** *A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying and mailing records to the Patient or the Patient's designated representative. The maximum fees are: $0.75 per Page for up to 25 Pages, $0.50 per Page for Pages 26 –100, $0.25 per Page for Pages over 100, Minimum fee of $10.00 permitted.*

AGREEMENT FOR PAYMENT AND ACKNOWLEDGEMENT OF FINANCIAL INFORMATION

In consideration of the treatment of____ (hereinafter "Patient"), as a patient of Associates in Women's Healthcare, P.A., (hereinafter "AWH") the undersigned do hereby expressly agree to pay and guarantee payment in full for any and all charges for medical services and materials furnished to or for Patient by AWH.

Patient may obtain medical services and materials from AWH from time to time which will be added to the Patient's account. Patient's attending physician or her designee shall execute all written orders for the furnishing of such services and materials, and the charges for such services and materials shall be payable as herein provided.

If more than one individual signs this Agreement, their liability shall be joint and several. In the event of default in payment of any installment of principal or interest hereof, and if a default is not made good within fifteen (15) days, AWH may, without notice, declare the remainder of the unpaid balance at once due and payable. Failure to exercise this option shall not constitute a waiver of the right to exercise the same at any time. Upon default, AWH may employ a collection agency or an attorney to enforce its rights and remedies and the undersigned hereby agree to pay all collection fees as allowed by N.C. Gen. Stat 6-21.2, plus all other reasonable expenses incurred by AWH in exercising any of its rights and remedies upon default and any other fee and charges allowed by law.

I have read and understand AWH's Financial Information and Agreement for Payment. Original or Photostat of signature shall be considered valid.

X____

Signature of Patient or Legal Representative **Date**

MEDICAL BENEFITS AUTHORIZATION

I hereby authorize payment of medical benefits on my behalf, to be made directly to Associates In Women's Healthcare, P.A. for services rendered to me. I also give permission for any medical information relative to my claim, to be release to my insurance company, such as Operative Reports, Pathologies, Visit Notes or any other information pertinent in processing benefits for my treatment. Original or Photostat of signature shall be considered valid.

X____

Signature of Patient or Legal Representative **Date**