Mid-Carolina
Obstetrics & Gynecology
Since 1978

FINANCIAL POLICIES AND PROCEDURES

To Our Patients:
Declining insurance reimbursements as well as increasing paperwork required by insurance companies has caused an increase in our staff and physician time and resources. We have found it necessary to impose the fees discussed below. These fees will not be billed to your insurance carrier and will be your responsibility. We are happy to discuss any questions you may have regarding these financial policies.

We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. These policies and procedures will establish the expectations you will receive from the WHA providers and also what we expect from you as our patient.

1. **APPOINTMENTS:** Please arrive 15 minutes prior to your appointment time. Failure to submit completed demographic information forms or this Financial Policy form may subject you to reschedule your appointment.
2. **CO-PAYMENTS, DEDUCTIBLES, AND FEES:** Co-payment, insurance deductibles and fees for service, not covered by your insurance policy, are typically collected at the time a service is rendered. We accept Cash, Visa, MasterCard and American Express.
3. **INSURANCE:** Patients must complete and sign information/insurance forms prior to seeing the physician or other provider. A current insurance card must be presented at each visit, if not you will be responsible for payment in full at the time of visit. You will receive a refund (within 30 days) upon payment by your insurance company. If WHA is not contracted with your insurance carrier, you are responsible for payment in full at the time of your visit. If your insurance company deems your visit a non-covered service, you will be responsible for payment in full.
4. **MAIL ORDER MEDICATIONS:** You are responsible for obtaining any necessary insurance prior authorization requirements for your current medications. Please provide the appropriate completed forms at the time of your visit for us to accommodate your needs.
5. **AFTER HOURS CONSULTATIONS/ PRESCRIPTION REFILLS:** For non-emergent issues or prescriptions we ask that you please call during regular office hours; otherwise a charge may be billed to you.
6. **MISSED APPOINTMENT:** You (not your insurance company) will be charged for a missed appointment unless cancelled 24 hours in advance.
7. **LAB BILLS:** If you have questions about your laboratory bill, please contact the lab directly.
8. **PAST DUE ACCOUNTS:** Payment is due when services are rendered. If we file your insurance claim and they (insurance company) satisfy their responsibility but there is a remaining balance that is your responsibility, you will receive three bills from WHA. If you have not paid in full or arranged and honored a payment plan within the three (3) months, we will refer your account to a collection Attorney. They in turn will report your past due status to a Credit Reporting Agency. Any fees incurred by WHA for Attorney or Court costs will be your responsibility.
9. **PREVENTIVE PHYSICAL VISITS:** Please be aware that most insurance companies cover one (1) preventive physical visit per plan year. Additional concerns or problems addressed at this visit will qualify as an additional problem visit and billed as such. There may be additional co-pays, deductible or co-insurance to address these additional concerns or problems at this visit. It is your responsibility to verify your benefits and financial responsibility before your appointment.
10. **COMPLETION OF FORMS:** A fee will be charged as patient responsibility for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability, FMLA, and Leave of Absence, also Letters regarding flying and or airline tickets, coverage of Birth Control Pills, letters to employers and Merck Medco Rx forms.

This is an agreement between you, the patient, and **Women's Health Alliance, PA pka Mid-Carolina Ob/Gyn PC.** By signing this agreement, you agree to abide by all the policies and procedures stated within.

Patient's Name: ______________________________ **Date:** _____/_____/_____

Signature of Patient or Responsible Party: ______________________________

Witness Signature: ______________________________