WOMEN'S HEALTH GROUP, P.A.

2209 South Sterling St.
Suite 400
Morganton, NC 28655
(828) 580-4661

2293 Sugar Hill Rd.
Suite C
Marion, NC 28752
(828) 652-3019

INSURANCE INFORMATION AND FINANCIAL RESPONSIBILITY

At Women's Health Group (WHG), we want to assist you in the financial management of our relationship by providing you with information about payment for professional services rendered. Be assured that we will be ethical and fair concerning any billing or collection concern you may have. If you have any questions, our billing managers will be happy to talk with you.

Participating Insurance Plan – Insurance coverage is an agreement between patient and insurance carrier. As a courtesy to our patients and if you are contracted with an insurance company, we will file claims with them.

- ✓ You are responsible for knowing your insurance policy coverage – deductibles, co-insurance and any pre-existing condition exclusions.
- ✓ You are responsible for presenting all current available insurance cards at the time of service. If you fail to provide your cards, you will be required to pay, in full, for all charges for that visit. If you are able to provide the card in the time allowed (usually 180 to 365 days) for filing with your insurance carrier, we will refund any covered fees and file your insurance.
- ✓ You are responsible for all co-pays, deductibles, and co-insurance at the time of service.
- ✓ After your carrier has processed your claim, you will receive a statement for services, which is due and payable within 30 days of the statement.
- ✓ You are responsible to remit payments for charges not covered by your carrier, and to ensure that your carrier remits payment to your account.
- ✓ If it is necessary for you to undergo surgery, we will help you determine which services your insurance carrier will cover and which fees will be your responsibility. Payment will be due prior to your surgery. WHG accepts cash, debit card, MasterCard or VISA.
- ✓ Any change in your insurance, especially during pregnancy, should be communicated to WHG immediately to insure accurate claims filing on your behalf.
- ✓ You are responsible for insurance follow-up with your plan regarding student status forms, annual employer claim forms, accident/injury information and terminated insurance plans.

Non-Participating Plans – As a courtesy to our patients, our Billing Department will file claims with your insurance carrier.

- ✓ You are responsible for all "out-of-network" patient responsibility at time of service unless other payment arrangements have been made. This would include any co-insurance, deductible, and the difference between carriers allowable and our standard fee.

Self-Pay – Patients with no insurance coverage will be considered self-pay.

- ✓ Self-pay patients will sign a form indicating that they have no health insurance.
- ✓ Self-pay patients will pay in full at the time of service or arrangements must be made in advance. A 20% discount is offered for payment that are made in full.

Dependent Children Services

- ✓ The responsibility for payment for services rendered to any dependent children whose parents are divorced or separated rests with the parent who seeks the treatment.
- ✓ Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Payment and Other Services

- ✓ For your convenience, WHG accepts cash, check, debit card, MasterCard or VISA for payment of services. There is a $25 service charge for checks that are returned.
- ✓ There is an administration fee of $10 payable in advance for us to complete more than two copies of a disability form following surgery or delivery. (Please allow 24 – 48 hours for our staff to complete these forms.)
- ✓ An administration fee is charged, payable in advance, for you to receive a copy of your medical records. The fee may be waived if your records are sent directly to another physician.

Failure to adhere to WHG's financial responsibility policies could result in your account being turned over to an outside collections agency.

_____ **I DO NOT HAVE** health insurance coverage.

_____ **I HAVE** health insurance coverage with _____.

I have read the above financial responsibility policies and agree to be responsible for any charges incurred by me or not payable by my insurance company. I also agree to be responsible for any legal fees and/or court costs incurred as a result of my failure to pay for services rendered.

_____ _____

Patient Name Date

Our staff has been instructed to make every effort to assist you in managing your account. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.