Office and Financial Policies

Thank you for reviewing the following office and financial policies. We commit to put forward our best efforts to provide you with the most up to date, skilled, and compassionate health care possible. We also agree to:

- Provide you and/or your insurance company with a timely and accurate statement of all charges for services rendered.

- Explain fully all charges for services rendered and acceptable payment methods.

- Secure all pre-authorizations and/or referrals that your health insurance plan requires us to obtain for your ongoing care or treatment.

In return we respectfully ask you to agree to the following:

- All appointments must be cancelled 24 hours prior to your scheduled appointment. Failure to cancel within this time frame will result in a charge to your account. If you are an established patient a $30.00 fee will be charged to your account. If you are a new patient or are scheduled for a procedure, a $100.00 fee will be charged to your account.

- If you are a patient who we requires an in-person interpreter, you will be responsible for the full fee for the interpreter if you no show your appointment or fail to cancel with greater than 24 hours' notice.

- If you are more than 15 minutes late for a medical appointment, you may be asked to reschedule or to see a different provider.

- Since our ultrasound schedule is generally full, we are unfortunately not able to accommodate patients who are running late, or to wait for family members to arrive. If you or your family members are more than 10 minutes late for an ultrasound appointment we will not be able to complete your procedure without affecting other patients, and will reschedule your appointment to the next available date. If you need to be rescheduled and our schedule is full, this may require scheduling you at a different facility which may results in higher charges to you. For these reasons we strongly recommend arriving 10-15 minutes prior to your ultrasound scheduled time.

- It is your responsibility to inform us of any changes to your account, such as phone number, insurance, or address changes. If you do not provide us with the correct information and we are unable to receive payment as a result, you will be responsible for the balance.

- As a courtesy to you, we will file your insurance claim for you. If your insurance is inactive or does not cover the services provided, you will be responsible for payment. Any balances older than 90 days, which have not been paid by your insurance company, may be billed to you. Any balances remaining after your insurance has paid will be due on receipt of a statement from our office. If your payment is not received within 60 days your account may be referred to a collections agency.

- If your insurance doesn't pay under the pre-existing clause then all services will be the patient's financial responsibility.

- It is your responsibility to confirm with your insurance if we are in or out of your network, and if the service you request is covered by your insurance.
- All co-pays, co-insurance and deductibles must be paid at the time of service. If you are having a baby, having surgery or being admitted to the hospital, we will collect your deductible before your delivery or procedure.
- Any accounts with outstanding balances must be paid prior to any additional services being rendered.
- A $25.00 charge will be charged for any returned checks. Checks will be processed electronically.
- For your personal use there is a $6.50 charge for your medical records, unless requested by another physician.
- If you require short term disability, FMLA or other forms to be filled out by us, these forms will be completed for a fee of $10.00 per form.
- As a convenience to our patients, we provide a MedFusion blood draw station in our office. Charges for most lab tests, including pap smears, are not included in the charges from our office and are billed separately by MedFusion. These charges are NOT included in your regular statements from Complete Women's Care Center. It is your responsibility to understand your insurance benefits for lab work.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.
- We make every attempt to code and file claims accurately according to the services rendered and your healthcare provider's documentation in your medical record. We are required to code and bill for the type of visit that is performed, not the type of visit that is scheduled. Laws regarding insurance fraud and abuse prohibit us from changing your procedure and/or diagnosis code in order to get the claim paid.
- **Our office prefers to use email to notify patients of lab results, reminders and other important office information. Please allow 2 weeks to receive notification of your lab or test results. I understand that this office cannot be responsible for information loss or delays that are due to technical factors beyond this office's control.**

Please clearly print your preferred email address below if you consent to using email for these preferred communications:

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I have read and understand the above office and financial policies and agree to be bound by these terms. I also understand and agree that Complete Women's Care Center may amend such terms from time to time. I have received/read a copy of the HIPAA statement.

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Print Name Signature Date

Thank you. We look forward to having you as our patient.

Notice of Cancellation Fees

As a courtesy, we request that if you must cancel you do so 24 hours prior to your scheduled appointment. Failure to cancel within this time frame will result in a fee charged to your account.

- **Established Patients - $30.00**
- **New Patients - $100.00**
- **Procedures - $100.00**
- **Cosmetic Gyn - $200.00**

If you are a patient who requires an in-person interpreter and you no-show your appointment or fail to cancel with greater than 24 hours' notice, you will be responsible for the full interpreter fee, as assessed by Language Acquisition Services.

We understand that unforeseen circumstances may arise. For your convenience, a member of our staff will contact you by telephone shortly after a missed appointment to assist you with rescheduling.
The fee will be assessed to your account and we request payment prior to scheduling a future appointment.
I have read and understand the above Notice of Cancellation Fee policy presented by Complete Women's Care Center.

____________________ _________________________ __________

Print Name Signature Date

Medical Records Policy

As a patient, you have the right to request a copy of your Medical Records. You may do so by completing an Authorization to Release Healthcare Information form, which is located on our website www.completewomenscarecenter.com. Please allow 3 – 5 business days to process your request.

- As a courtesy, we will request or send your Medical Records to an outside physician's office.
- For your personal use, there is a $6.50 charge for your medical records.

I have read and understand the above Medical Records Policy presented by Complete Women's Care Center.

______________________	______________________	____________
Print Name	Signature	Date

Ultrasound Appointment Policy

Since our ultrasound schedule is generally full, we are not able to accommodate patients who are running late, or to wait for family members to arrive. If you or your family members are **more than 10 minutes** late for an ultrasound appointment we will not be able to complete your procedure without affecting other patients, and will reschedule your appointment to the next available date. If you need to be rescheduled and our schedule is full, this may require scheduling you at a different facility (for example at the hospital or at free standing ultrasound facility) which may results in higher charges to you. *For these reasons we strongly recommend arriving 10-15 minutes prior to your scheduled ultrasound time.* Thank you for your assistance in maintaining our schedule and keeping your care on schedule.

I understand the above policy and that I will not be able to have an ultrasound performed if I am more than 10 minutes late for my scheduled appointment, and will not be able to wait for family member who are late.

___________________________	___________________________	___________
Name	Signature	Date