# Excellence in Women's Healthcare

**PATIENT FINANCIAL RESPONSIBILLITY ACKNOWLEDGEMENT**
**Office Payment and Financial policy**

**CO-PAYMENTS**: co-payments are due at each office visit unless previous arrangements are made.

**INSURANCE**: We will bill your insurance company as a courtesy. However, when there are balances due to co-insurance, co-pays and deductibles, we will collect at the time of service. Any patient balances that may occur beyond insurance responsibility are due in full within 30 days**. PLEASE NOTE: it is the patient's responsibility to determine whether their insurance plan is in network with the provider. Not all plans are the same.**

**SELF-PAY**: We offer 30% discount if paid in full at the time of service, otherwise, please bring at least half of the estimated charges and make arrangements for monthly payments.

**RETURNED CHECK**: if a check is returned by your bank, you will be charged a $35 return check fee. Balance must be paid in cash prior to your next appointment.

**NO SHOW**: due to limited appointments, no shows or cancellation without 24 hour's notice will be charge a fee of $50.

I have read the above Office Payment policy and as a patient, legal guardian of a minor or impaired patient, I understand that I am financially responsible for payment of my account. I understand there is no interest charged unless the account balance is over $500, then a 2% interest fee is added to the total balance each month until balance is below $500. I am aware that delinquent accounts beyond 90 days are subject to outside collection agency at my own expense.

_____ _____

Signature printed name

_____

Date