FINANCIAL POLICY AGREEMENT

Welcome

Thank you for choosing Women's Health Associates of Southern Nevada (WHASN). We consider it an honor to be given the opportunity to assist you with your medical needs. Our providers are committed to being leaders and advocates in the pursuit of excellence in women's health care. We strive to provide the highest quality of care possible with integrity, honesty, compassion, and efficiency. Our healthcare providers do not discuss financial obligations or insurance coverage. This allows the providers to focus their full attention on your medical needs. Understanding our financial policy is important to a successful physician-patient relationship. We make every effort to keep our fees reasonable while at the same time covering the cost associated with the services we provide. Our financial agreement is indicative of our respect for your right to know, ahead of time, what our expectations are for the patient's financial responsibility. Payment of your bill is considered part of your overall healthcare service provided by WHASN. If you are unable to have follow-up care or testing ordered by your provider due to financial burden, please ask to speak with the office administrator. We will do our best to assist you with getting the medical care needed.

Patient Information

All patients must complete our Patient Registration Form prior to their visit with the physician. It is the patient's (parent/guardian) responsibility to notify this office of any information changes. This includes changes to your address, phone number and insurance information. You are required to provide updated personal demographic information, a current copy of your insurance card, a picture ID, and payment of any outstanding balance for each visit.

Fee and Payments

WHASN's fees are based on reasonable and customary community standards. Fees are based on the medical complexity of the service provided. There are many factors which must be taken into consideration by the provider when selecting the appropriate procedure codes to accurately reflect the services provided. We will do our best to provide you with an accurate estimate of your financial obligation. However, due to the complexity of the information which must be considered, the final amount of your financial obligation can only be determined after the physician has provided a complete accounting of the services provided and, if applicable, your insurance company has processed any claims related to those services. WHASN requires payment for the estimated patient responsibility at the time of your visit. This includes copays, coinsurance, deductibles, and non-covered services. WHASN accepts cash, credit card and debit card. Checks are not accepted at providers' offices. **Patient payments will be applied to the oldest balance, regardless of the payment date.**

Insurance

Women's Health Associates of Southern Nevada, as a courtesy, will file an insurance claim with your primary insurance company. In order to properly bill your insurance you are required to disclose all medical insurance coverage information. This includes any insurance coverage provided under a parent's or spouse's policy. Failure to provide complete and accurate information on all current insurance policies will result in the patient responsibility of the entire bill. Not all services are a covered benefit in all insurance policies. You are responsible for knowing and understanding the benefits, limitations and exclusions of your policy. You are responsible for verifying if the provider you are seeing is

contracted with your insurance plan. You are also responsible for obtaining a referral or prior-authorization prior to seeing our providers, if required by your insurance plan. Our office will only obtain authorization for services rendered by a WHASN provider. If your insurance company denies payment for services rendered by our office as; out of network, cosmetic, exhausted benefits, experimental, no referral, or as a result of inaccurate or incomplete information you provide, you will be financially responsible for the entire bill.
Patient/Guardian Signature:
Date:

Medicaid Coverage Medicaid coverage is offered through the federal government to those who qualify. The government requires the services to be billed to Medicaid as the last coverage option. This means the patient is required to provide both Medicaid and the physician with any and all medical coverage information prior to services being rendered. This includes coverage through employer, spouse, parent or private policies. You do not have the option of using Medicaid as your primary (first) insurance coverage, when you are covered under any other medical insurance policy. This rule applies even if the other insurance policy does not cover all services being provided. It is very important that you provide the physician's office with complete insurance coverage information. Failure to provide the required information, will result in you being financially responsible for the services rendered.
Patient/Guardian Signature:
Date:

Please note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not on coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is inappropriate and is considered insurance fraud. While a patient has the right to request an amendment to her chart, all services will be billed according to the provider's documentation.

Account Balances/Delinquent Balances

Payment is expected at the time services are rendered. In some circumstances, there may be additional financial obligations not known at the time of your visit. In these circumstances we will send a statement to the address provided on your patient registration form. You are required to submit payment in-full within 15 days of the original statement date. If you are unable to pay the account balance in-full, you may request approval for an acceptable monthly payment arrangement. If you do not pay your account balance in-full within 45 days, or secure and maintain an approved monthly payment arrangement, your account will be considered delinquent. Once your account is in the delinquent status, it will be processed and assigned to the Past Due Accounts Department or placed with an outside licensed collection agency. This will result in late fees up to an additional 50% of your account balance. Once your account is assigned to the Past Due Accounts Department or to a collection agency, we are unable to reduce or remove the late fees. You are financially responsible for your entire account balance, as well as all late fees, all attorney's fees, and all legal fees incurred, in an attempt to collect your delinquent account balance.

Account Credits

Because we can only estimate your financial responsibility for services provided by WHASN, there is a possibility you may have a patient credit after your insurance has processed the claims submitted. It is very important for you to review the explanation of benefits (EOB) you will receive from your insurance company. It will provide detailed information on your final financial responsibility for services provided by WHASN. **If, after reviewing the EOB, you believe you have a credit due to you, please contact the billing office so we can review your account and process a refund for any credit remaining on your account.** If

you have any questions or need assistance with understanding the EOB you receive, you are welcome to contact the billing department for assistance.

Office Visits

You are required to pay any co-pay, co-insurance or deductible that may apply to your office visit. Additional services performed (ultrasounds, biopsies, cultures, labs, injections, etc.) during your office visit are not included in the fee for the office visit. You are responsible for payment of the additional services rendered.

Surgical Procedures

Surgery deposits are required and must be paid prior to your pre-operative visit. The deposit consists of your deductible (if not met) and your co-payment or co-insurance. You should contact the provider's office prior to your pre-operative visit to discuss the amount expected.

Obstetrical Care

Payment for obstetrical services is addressed individually. You will be provided an Obstetrical Financial Agreement. The agreement will explain the services included in the obstetrical fee and the services not included. It will also provide an estimate of your financial obligation based on your insurance benefits and when payment is required.

Laboratory Services

Your provider may order laboratory services to assist in diagnosing your condition or as preventative care to determine your current health status. Your provider will choose an in-network lab to send any blood work, cultures, or other tests based on their preference. Your provider Your insurance benefits may not cover all services provided or ordered by the provider. This includes: pap smears, testing for sexually transmitted disease, screening and diagnostic labs, genetic testing and drug screening. In some instances these services may be applied to your annual deductible or not covered. It is the patient's responsibility to know the coverage, limitations and exclusions of your insurance policy.

Returned Checks

WHASN's central billing office accepts checks as payment on an account. In the event a check is returned by the bank for "non-sufficient funds", "closed account", "return to maker", "check voided", "stop payment" and "un-authorized signature", a $25.00 fee will be assessed to your account. We may choose to proceed with legal action which will result in additional fees to you or the guarantor of the account. You are responsible for the additional fees.

Cancellation / No Show Policy

If it is necessary to cancel your scheduled appointment, we request that you notify us at least 48 hours prior to the appointment. A "no-show" is someone who misses an appointment without cancelling it at least 48 hours prior to the scheduled appointment time. A failure to present at the time of a scheduled appointment will be recorded as a "no-show". You will be charged $25 for "no-show" appointments.

FMLA / Disability Forms

There is a $25.00 charge for each FMLA/disability form/signature completed by this office. Payment is due at the time the form is submitted. All FMLA/disability forms are completed by the office staff. There is generally a 7-14 day waiting period for the completion of these forms. The physician's documentation in your medical chart serves as the basis of all FMLA/disability forms and cannot be enhanced by yourself or the office staff. It is important that you understand the difference between FMLA and disability forms. Disability forms can only be completed after the physician has determined the patient has a medical condition that warrants the patient to be off work. Normal symptoms during pregnancy (nausea, vomiting, headaches, swelling, pelvic pain/pressure) do not typically qualify as a medical disability.

Embassy Letters

WHASN understands the importance of having family support following deliveries and surgeries. We are happy to provide a letter requesting approval for a family member to travel to the United States to assist you during your recovery period. The fee to complete a letter to an Embassy is $100.00

Minor Patients

The parent or guardian accompanying the minor is responsible for full payment of services provided.

Assignment of Benefits

I hereby authorize and assign all payments and/or insurance benefits for medical services rendered to me directly to Women's Health Associates of Southern Nevada. I hereby authorize Women's Health Associates of Southern Nevada to release medical information necessary to obtain payment for services rendered by providers of Women's Health Associates of Southern Nevada**. BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND IN ITS ENTIRETY, THE INFORMATION IN THIS FINANCIAL POLICY AGREEMENT. I UNDERSTAND THAT BY SIGNING THIS FINANCIAL POLICY AGREEMENT, I AM AGREEING TO THE TERMS AND CONDITIONS PROVIDED WITHIN THIS AGREEMENT.**

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date