WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

HOURS M-F 8-12 & 1-5

FINANCIAL POLICY

We are doing everything possible to hold down cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance by our billing department. This includes applicable co-insurance and co-payments for participating insurance companies. We accept cash, personal in-state checks, VISA and MasterCard. **OB prenatal payments will be due in monthly/weekly payments, per the OB fee sheet, by the 28th week of pregnancy. These funds will be distributed once the claims are processed as insurance requires us to bill Globally.** There is a **$35.00 service charge** for all returned checks. Worthless checks will be forwarded to the **Hot Check Division** of the county in which it was written if not resolved in **five business days. If you pass a worthless check for a visit the prompt pay discount will be forfeited. Stop payment on a check written to our business will result in small claims court. All discounts will be lost as prompt pay is set aside for monies being available that day.**

INSURANCE AND STUDENT STATUS

We bill **primary** participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within **45 days** of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. **OUR OFFICE WILL NOT FILE SECONDARY INSURANCE UNLESS AUTOMATICALLY FORWARDED BY YOUR PRIMARY.** Please note once you start your care as **private insurance** you will stay private insurance **OR** become **self pay**. We will **NOT** file Medicaid if you lose your private insurance.
You must provide an insurance term letter at our request. Regarding health spending accounts: Payment/deductible/co-insurance is due at time of service unless the funds are immediately available (i.e. Credit Card attached to the account). If you do not provide the correct order of your insurance/insurances, you will be responsible for the entire balance as we are held to a 90-day timely filing contract. Example-you are covered by your parents/spouse and you have insurance as well. It is your responsibility to inform us of your primary

PAYMENT OF BALANCE/COLLECTION AGENCY

All outstanding accounts with Women's Health Specialists of North Texas MUST be paid in full before an appointment will be made. Please understand if one member of the family is in collections that balance must be paid prior to any services rendered to another family member.
You will receive your first statement once we have received the payment from your insurance. We will apply this to the dates of service the payment was intended. If there is a balance due a payment plan will be set up for you.
If a payment is missed it may be necessary to forward your account to an Outside Collection Agency.

REFUNDS and MEDICAL RECORDS

Overpayments must be requested in writing. Refunds require 30 days to process. Medical records will be processed in 48-72 hours once the release form is received by our office. Please note due to conflict you are NOT allowed to switch physicians in the middle of ongoing care such as pregnancy or other surgical care.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late cancelled appointments. ***Excessive abuse of missed/late cancelled appointments may result in dismissal from the practice.***

2460 North I-35E • Suite 165 • Waxahachie, Texas 75165
2800 East Broad Street • Suite 212 • Mansfield, Texas 76063
Phone: (972) 938-3493 • Waxahachie Fax (972) 937-5608 • Mansfield Fax (817) 225-0797

REV.01.17.2017

PATIENT INFORMATION

Date ____________________

Name ____

Address ________________________________ City/State/Zip ____________________________________

Home Phone __________________ Work Phone __________________ Cell Phone __________________

Age _________ Date of Birth _____________________ Marital Status ____________________________

SSN ________________________ DL ________________________ State _________________________

Employer __________________________________ Occupation ___________________________________

Email Address ____

INSURANCE POLICY HOLDER INFORMATION

Policy Holder Name ____

Address _________________________________ City/State/Zip ___________________________________

Home Phone __________________ Work Phone ___________________ Cell Phone _________________

Age _______ Date of Birth _______________________ Marital Status ____________________________

SSN ______________________ DL ________________________ State ____________________________

Employer __________________________________ Occupation ___________________________________

Relationship to Patient ____

EMERGENCY CONTACT

Name ______________________________________ Phone Number ______________________________

Relationship to Patient ____

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

Patient Preference Regarding Communication of Health Information

I____hereby give permission to **Women's Health Specialists of North Texas** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

You may contact the following:

__________________________________ __________________________________

Name Relationship **Phone Number**

__________________________________ __________________________________

Name Relationship **Phone Number**

__________________________________ __________________________________

Name Relationship **Phone Number**

_________I do **NOT** wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact (Please check all that apply)

_____ OK to leave a message on my **HOME-OR-CELL PHONE with detailed information.**

_____ Leave a message on my home phone with a **call-back number only.**

_____ OK to leave a message on my **WORK PHONE with detailed information.**

_____ Leave a message on my **work phone with a call-back number only.**

_____ **OK TO CONTACT ME REGARDING MY BILL THROUGH EMAIL.**

_____ OK to mail to my **home address** ____

_____ OK to mail to my **work/office address**____

_____ OK to **fax to this number**____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

____ ______________________________

Signature of Patient/or Legal Representative **Date**

____

Print Patient/or Legal Representative

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WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

CONSENT

(1) To receive general patient care and
(2) To use and/ or disclose protected health information for payment, health care operations, and as otherwise allowed by law.

(1) CONSENT GENERAL PATIENT CARE

By signing this form, you authorize employees, including physicians of **Women's Health Specialists of North Texas**, to render routine care to you during your office visits at **Women's Health Specialists of North Texas** (hereinafter "**WHSNT**") and to fulfill the orders of your physicians, including consultants, associates, and assistants of the physician's choice.

You understand that you are responsible for the total charges for services rendered which may include services **NOT** covered by your insurance companies. You agree that all amounts are due upon request and are payable to **WHSNT**. You further understand should this account become delinquent, you shall pay the reasonable attorney fees or collections expenses, if any.

(2) USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

WHSNT will maintain a record of care and services you receive at **WHSNT** offices. This consent only covers your protected health information created while you are a patient at **WHSNT**. Your protected health information pertains to your diagnosis and/or treatment at **WHSNT**, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to **WHSNT**'s use and/or disclosure of protected health information about you for treatment, payment, health care operation, and otherwise allowed by law. Our notice of health information practices provides information about how **WHSNT** and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of **WHSNT**'S notice of health information practices and had an opportunity to review it before signing this consent. In addition, by signing this form you acknowledge that you have received a copy of **WHSNT**'S financial policy.

THE DURATION OF THIS CONSENT IS INDEFINITE AND CONTINUES UNTIL REVOKED IN WRITING BY PATIENT.

______________________________	______________________________	______________
(Please Print Patient Name)	**(Patient Signature)**	**(Date)**
______________________________	______________________________	______________
(Please Print Legal Guardian Name)	**(Legal Guardian Signature)**	**(Date)**

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

FINANCIAL AGREEMENT PAGE TWO-SIGNATURE
By signing this, you have received the Financial Agreement, page one.

- **Co-payments, deductibles, coinsurance and/or global OB fees are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials _______

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial _______

- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial _______

- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial _______

- A $35.00 fee will be assessed for all returned checks. Initial _______

- We confirm appointments 48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a $25.00 cancellation fee. Initial _______

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over $50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than $50 will be available and processed upon request of the patient. Initial _______

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Women's Health Specialists of North Texas* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_______________________________________ _________________
Responsible Party Printed Name (Must be 18 or over) Date

_______________________________________ _________________
Responsible Party Signature (Must be 18 or over) Date

WOMEN'S HEALTH SPECIALISTS OF NORTH TEXAS

SELF INSURED PAYMENT AGREEMENT

You have represented to *Women's Health Specialists of North Texas (hereinafter "Practice")* that you are self insured (i.e. do not have health insurance that covers obstetrics & gynecology) for the following date(s)________________________________. By representing yourself as a self insured patient, you:

(1) are asking that the Practice not file any documents with an insurance company;
(2) will pay at the time of service;
(3) will receive a "prompt pay" discount off of the regular price; and
(4) are waiving any medical insurance benefits that you might have (understanding that if you do have health insurance, your insurance company might refuse to cover your services based on this wavier).

Women's Health Specialist of North Texas is only requiring you to make payment at the time of service based on your representation. Further, the Practice is only extending the "prompt pay" discount based on your representation. If your representation is false, you will be liable to the practice for any and all losses, expenses and/or damages incurred by Women's Health Specialists of North Texas.

____ ____________________
Responsible Party Printed Name (Must be 18 or over) Date