



1340 E. COUNTY LINE ROAD, STE. W INDIANAPOLIS, IN 46227
 (317) 497-6260 FAX: (317) 497-6261

OUR FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is a part of your care. Your clear understanding of our financial policy is important to our professional relationship. Please ask our staff if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete (in full) our Patient Information Form; and provide us with accurate insurance information including an insurance card at each visit before seeing the provider.
- Full payment is due at the time of service; we accept Cash, Checks, Visa, Master Card, Discover.

RESPONSIBLE PARTY

You will be responsible for your charges regardless of any divorce decree or court order regarding payment of medical bills.

MINORS ACCOMPANIED BY AN ADULT

A parent or legal guardian must accompany patients who are minors on the patient's visit, and must sign the financial statement for the patient, accepting responsibility for the account.

If you have...	You are responsible for...
HMO, PPO, AND POS plans With which we have a contract	<p><u>If the services you receive are covered by the plan:</u> All applicable co-pays and deductibles are expected at the time of the office visit.</p> <p><u>If the services you receive are not covered by the plan:</u> Payment in full is expected at the time of the visit.</p> <p>We suggest that you call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services. It is your responsibility to obtain all necessary referrals.</p> <p>We will file an insurance claim as a courtesy to you.</p>
Medicare	<p><u>If you have Regular Medicare, and have not met your \$100.00 Deductible, we expect it to be paid at the time of the service.</u></p> <p>Any services not covered by Medicare will be your responsibility.</p> <p><u>If you have Medicare as primary, and also have secondary insurance (Medigap): No payment is necessary at the time of the visit.</u></p> <p><u>If you have Medicare, as primary, but no secondary insurance: Payment of 20% is expected at the time of the visit.</u></p> <p>We will file an insurance claim as a courtesy to you.</p>
No insurance/Self Pay Commercial Insurance	<p>Payment in full at the time of the visit. If the total cost of the visit is not able to be determined, you will be asked to make an estimated payment and will be billed or credited for the difference. Please ask to speak with our staff if you need assistance on an extended payment schedule.</p>

NON-SUFFICIENT FUNDS CHECK

Your account will be charged \$20.00 for each time a check is returned for non-sufficient funds. If your bank does not honor these checks, you will be responsible for the payment of the check and additional charges within 10 days. If payment is not made, a claim will be file in court three (3) times the amount of the check, NSF charges, courts costs and any past due balance. Any future payments due to your account will need to made with cash or credit card.

COLLECTION POLICIES

If your account is 90 days delinquent, it will be subject to a 1.5% interest charge, monthly. If your account has not been satisfied within a reasonable period of time, your account will be sent to a collection agency or an attorney. If your account is given to an attorney for collection, you will be responsible to pay court costs allowed by law, cost of collection, and reasonable attorney fees. Patient care with our office will be cancelled once your account goes to collection.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us service you better by keeping your scheduled appointment.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Caring For Women's Health, and I authorize them to release any pertinent medical information to facilitate payment of the claim. I have received a copy of this policy.

Responsible Party Signature _____

Date _____