ATHENS HEALTHCARE FOR WOMEN, P.C. FINANCIAL POLICY

Thank you for choosing Athens Healthcare for Women, P.C. (AHW) for your OB/GYN care. This financial information was written to make sure you understand our payment procedures.

It is your responsibility to make sure we have your all of your current (active) insurance information. This allows us to file your claims to the correct carrier. Please make sure that you provide the receptionist with your *current* insurance information each time you check in for your visit. Patients who do not provide us with current insurance information will be billed directly for the service (s) received.

Insurance: AHW participates with many insurance carriers to include, but limited to: Aetna, Blue Cross Blue Shield, Board of Regents, Cigna, Coventry, First Health, Great West, Humana, Kaiser, Tricare and United Healthcare.

Co-pays: Co-pays are required by your insurance carrier to be paid in full at the time of your appointment. **We cannot bill for co-pays**. If you do not have your co-pay, you will have to reschedule your appointment.

Method of Payment: We accept cash, checks and money orders, Visa, MasterCard, American Express and Discover. We do not accept post dated checks.

Returned Checks: We will automatically re-deposit (one time) a check that is returned to the practice marked "NSF." Your account will be charged an additional $25. When a check is returned for a second time, the account will be re-charged the amount of the check.

Collections: Any accounts unpaid after 90 days will be placed to our outside collection agency. If this should happen, you won't be able to return to AHW for future care. As you know, having an account with a collection agency can affect your credit rating.

Dismissal: We cannot continue to care for patients who ***repeatedly*** choose not to pay their patient responsibility or are noncompliant with the physician's plan of care. When a patient is dismissed from the practice they cannot schedule an appointment or request prescriptions from the practice until their balance is paid and/or the physicians states they have become compliant. Please do not let this happen. Patients should contact our practice administrator if there is a concern.

Pregnant Patients- At the time of your first pregnancy visit you will meet with the Practice Administrator, to discuss your insurance coverage, payment options if you do not have maternity benefits, a high deductible, or any other questions you might have at that time.

Lab Services: Most patients who need lab work performed are referred to either PathGroup or Athens Regional Medical Center (ARMC) Lab Outreach. Patients having lab work performed will receive a bill from the lab if your insurance does not cover the tests 100%. You will also receive a bill from the pathologist when a pap smear is performed in our office and sent to the lab. The charge represents the pathologist's fee for reviewing the specimen and preparing a professional report of his/her findings. This report is sent to our office once completed.

Surgery: In addition to receiving a statement for the physician's professional fee for performing your surgery, you will be billed a facility fee by ARMC/St Mary's for use of the operating room, supplies and nursing services. You may also receive a bill from the hospital lab and pathologist.

Billing: First we will submit the claim to your insurance company. After we receive the explanation of benefits (EOB) we will apply payment if applicable and then send you a statement for the remaining balance based on the EOB. We expect patients to pay their responsibility once they receive their statement. If you have any questions about your statement, please call our billing department immediately. Also if you need to set up a payment plan to divide your balance into more manageable payments, please contact the practice administrator.

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Payment Guarantee: The undersigned agrees, whether signing as a patient or guardian, to guarantee payment of the account in accordance with the standard rates and terms of AHW. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where AHW has a specific contract with my PPO, HMO or third party payor. I further understand that any balance remaining after my insurance approves or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy. In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (of both), I agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collections fees, attorney fees, court costs, and contingent fees to collections agencies. AHW reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.

The provider of service has the right to terminate services based on noncompliance of this agreement. If this occurs you will be notified by certified mail. You will be given 30 days to find a new physician. If you experience a medical emergency within the 30 day period, our physician will provide you with his/her services.

Release of Information:
I hereby authorize AHW to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, alcohol/drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my insurance carriers, other third party payors, including the Health Financing Administration (Medicare) or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Workers' Compensation, or for other insurance purposes.

Authorization to Pay Insurance Benefits:
I hereby authorize the payment of any insurance or other medical benefits directly to AHW.

THE UNDERSIGNED CERTIFIES THAT SHE HAS READ OR HAS BEEN READ THE FINANCIAL AGREEMENT, THAT SHE UNDERSTANDS THE FINANCIAL AGREEMENT, THAT SHE HAS RECEIVED A COPY OF THE FINANCIAL AGREEMENT IF SHE DESIRES, THAT SHE HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT SHE MAY HAVE CONCERNING THE FINANCIAL AGREEMENT, AND THAT SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THE FINANCIAL RESPONSIBILITY AGREEMENT.

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Patient Name (Please Print) Patient's Signature Date

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Guarantor's Name (if under 18 or responsible for patient) Relationship to Patient Date