# *Women For Women*
## Credit Policy/Assignment of Benefits Form

Welcome to Women for Women. The following outlines our patient financial responsibility policy.

Payment for services provided by Women for Women is required at the time of service unless prior arrangements have been made or you are insured by a company that has a current contract with us. Deductible and non-covered services are due at the time of service. If we are contracted with your insurance company, we will bill your insurance company for you. **It is your responsibility to determine what services your insurance will cover**. If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this to your health care provider. We will bill a secondary insurance, **unless the secondary insurance is MEDICAID (IDPA). We do not accept Medicaid (IDPA) as a secondary insurance.**
If Women for Women is **not contracted** with your insurance company and you need a major medical service (such as having a baby or needing surgery), we will provide you with the opportunity to complete a financial agreement. We will help you estimate the cost of the medical services provided. A financial agreement form will be completed which should include the cost of the surgery, any deductible due, an estimate of your insurance payment at out-of-network rates and an estimate of the amount that you will need to pay for the service. Financial arrangements should be discussed in advance so that a specific payment plan can be arranged if necessary. As a courtesy, we will bill your insurance for you. **When you receive the statement for your services, you are responsible for payment at that time.** Services provided by outside laboratories (i.e. blood work, Pap test, or biopsies) will be billed directly to you by the outside provider.
You will receive a statement showing in detail charges incurred during the statement period and the amount due. All fees are payable within 30 days of receiving the statement. **Any late payment after the initial 30 days will be assigned a $15 late monthly fee.** As the patient, you are responsible for complete payment charges that you incur whether covered by your insurance or not covered by your insurance. Should your insurance send payment to you, you agree to forward the payment to Women for Women within 48 hours.

All returned checks will be subject to a **$30** handling fee.

**If your overdue balance is sent to a Collections Agency, you will be responsible for all additional fees (30% of the sum of your outstanding balance and Collection Agency fees) the Collections Agency charges our practice for handling your account.**

**I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY SUSAN SVIENTEK, MD,SC/*WOMEN FOR WOMEN* REGARDLESS OF ANY LIABILITY CLAIMS, INSURANCE, LACK OF INSURANCE, OR INSURANCE PLAN LIMITATIONS. SUCH LIMITATIONS MAY INCLUDE BUT ARE NOT LIMITED TO PRE-AUTHORIZATION, PRE-CERTIFICATION OR PCP REFERRAL, MEDICAL NECESSITY LIMITATIONS, AND INCREASED DEDUCTIBLE OR CO-INSURANCE AMOUNTS.**

**MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE BILLING POLICIES OF SUSAN SVIENTEK, MD, SC /WOMEN FOR WOMEN AND AGREE TO COMPLY WITH THEM.**

**I AUTHORIZE WOMEN FOR WOMEN TO RELEASE TO MY INSURANCE CARRIER AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE UNDER THEIR COVERAGE. I FURTHER AUTHORIZE MY INSURANCE COMPANY AND ITS CARRIERS TO DISCLOSE ANY INFORMATION REQUESTED REGARDING CLAIMS FOR MEDICAL BENEFITS TO WOMEN FOR WOMEN. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.**

**I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO WOMEN FOR WOMEN FOR SERVICES FURNISHED TO ME BY ITS PHYSICIANS AND STAFF UNLESS I HAVE PAID FOR THE SERVICES AND AM BILLING THE INSURANCE DIRECTLY.**

_____ _____
Patient Name (please print) Date

_____ _____
Patient Signature or Signature of Responsible party Relationship to Patient