This General Financial Policy should be read and understood prior to receiving any service.

INSURANCE:

- **Every person's Insurance Plan is different and only you can be responsible for knowing your plan.**
- In order for us to bill your insurer for services rendered, it is your responsibility to provide our staff with a copy of valid Insurance Card, we can make a copy of your card for you for our records.
- For New Patient and if you do not have Insurance Card at the time of visit, 100% visit charges are due at the time of service.
- In plans where we are a participating provider, all copays and deductibles are due and payable at the time of visit/treatment. There are many national insurers and payers and/or plans that we participate with and are In-Network Provider. **However, it is your responsibility to know/ensure if we are a Participating Provider with your insurance and your particular plan.**
- We do not encourage you seeing us for being out of network; if you do visit as an out of network we could bill on your behalf and out of courtesy but require you to pay in full at the time of visit/treatment.
- Some services and perhaps all of the services provided may be non-covered services and/or may not be considered reasonable or medically necessary under your plan/policy; whether the insurance company pays or not the unpaid balance amount is your responsibility.

Multiple Insurance Coverage:

If you have multiple insurance coverages, it is your responsibility to inform us of all coverages and ensure to complete Insurance Information section of New Patient Insurance Information Form - REGISTRATION for billing preferences, that is which one to be billed as primary or secondary.

Pre-Certification /Pre-authorization:

If your insurer requires precertification prior to Office visit, In-Patient/Out-Patient Hospital stay/services, we will work with you, as a courtesy, in getting pre-certification done. However, it is your responsibility to ensure all services availed by you are approved by your insurer.

College Student Covered Under Parent's Insurance:

If you are a college student and covered under your parent's insurance plan, it is required that you fill out Student Status Verification Form and send it to the insurance company each semester. If insurance database is not updated accordingly, insurance company will not pay the claim and you and/or your parent assume the responsibility of entire balance.

HMO PLANS and Referrals Requirement:

Referral required by HMO Plan is strictly patient's responsibility and should be obtained and presented prior to any treatment. If the physician sends you for outside tests/other specialist evaluation and referrals are necessary, you must inform us and allow ample time to receive the referral prior to scheduled tests / specialist appointment.

________ Initials

PATIENT SHAREs / RESPONSIBILITIES:

CLAIMS UNPAID OVER 90 DAYS: If your insurance has not paid within 90 days of filing of our claim, the un-adjusted full amount of filed claim will become patient's responsibility regardless of REASON FOR REJECTION/DENIAL. Resolving delays of adjudication with your insurance is solely your responsibility.

COPAYS/COINSURANCE/DEDUCTIBLES: These charges fall under Patient Responsibility and must be paid before receiving any services/treatment.

PAST DUE BALANCE: All previous balance needs be cleared prior to receiving additional services. Unpaid balances might require a re-scheduling of your appointment unless a prior arrangement/payment plan is in place. We allow paying your full balance via 3 equal installments spread over 3 months maximum.

MISSED APPOINTMENT: Unless cancelled at least 24 Hours in advance our policy is to charge a minimal fee for missing an appointment.

RETUREND CHECKS: Returned checks are subject to $25.0 service charge.

DECLINED CC TRANSACTIONS: Declined credit card transactions with signed/agreed Auto Recurring Authorized Installment Plan payments in place are subject to $25.0 service charge.

HOW WE BILL YOU FOR SERVICES RENDERED:

As indicated above, all services are required to be paid up front including copays/coinsurance/deductibles. Unfortunately, to date we do not have any Cost Estimation Tools for visits to Physician Offices to arrive at exact Patient Share Responsibility against services rendered for reasons beyond our control. We trust you for clearing your dues as a priority and once we bill you for Patient Share Responsibility established against claim filed and adjudicated by your insurance company.

As a general policy we bill based upon EOB/P (Explanation of Benefits/Payments) issued by the Insurance Company for services rendered/claimed; you would receive your copy of EOB/P in mail from your insurance company establishing billed charges as your responsibility. If you need a copy of EOB/P before you pay; EOB/s can be found on your insurer's website upon Member Login. We can also provide you with a copy of EOB/EOP for a nominal fee of $5.0/EOB.

We send billing Statements via USPS First Class mailer to an address provided by you. In case of in-complete and/or un-deliverable mailing address provided we may bill you electronically via secure email application. Keeping your account Current and in good standing via prompt/timely payment is of essence and allows us to continue to provide needed medical services. In order to keep the Account Status 'Current' please ensure your mailing and emailing addresses are accurate and up to date in our records.

We Thank You for choosing UpToDate Healthcare for Women (UHCW) as your healthcare provider. Furthermore, we understand temporary financial problem may affect timely payment from you. We encourage you to promptly inform us of those situations for assistance in the management of your account so we can help you keep your account Current and prevent Delinquency.

Your signing/accepting of this General Financial Policy ensures that we are in Agreement on billing/payment issues pertaining to Patient Share / Responsibility towards medical services rendered to you.

Please check Applicable Box:

Signature ______________________ Date ________ Patient Authorized Representative

Signature ______________________ Date ________ Parent/Guardian Relationship: ______________