

Financial Policies Statement

We are delighted that you have entrusted your care to the physicians and staff of Women's Health Specialists of Dallas, P.A. (a.k.a. WHSD or WHS Dallas). We all look forward to helping you reach your health care goals. Our practice believes that a good physician/patient relationship is based upon understanding and open communication. To that end, the policies outlined below are intended to provide understanding of our mutual expectations regarding the financial guidelines of WHSD. We hope you will find this information helpful.

Overview of our Respective Financial Responsibilities

• **WHSD's Responsibility** – To post charges and payments accurately. To process claims and statements to the responsible party based on the best information available to us. This includes direct insurance billing and patient billing for remaining balances. To provide accurate financial counsel to patients who contact our billing department.

• **Patient's Responsibility** – To assure that WHSD is provided with the most current insurance information known. To provide timely payment to WHSD for all balances known to be the responsibility of the patient (whether co-pays at the time of service or balances due following insurance payments applied - i.e., deductibles and co-insurance).

General Payment Policies

Office Visits

We require that all PPO and HMO co-payments, Deductibles and/or Co-insurance be paid at the time of the visit.

Insurance

We ask that you bring your insurance card with you each time you visit our office. If you do not have your insurance card, you may be asked to pay at the time of service and sign a waiver of responsibility.

Balances

You are responsible for any balance your insurance does not cover. We will file your insurance claim and allow them 45 days to render payment. After 45 days, if we have not had a response from your insurance company, you will be responsible for the entire balance.

Changes in Insurance Coverage

If there are any changes to your insurance, it is your responsibility to bring that to our attention immediately (even if you do not have your new insurance card with you). Delays in communicating these insurance changes may result in the balance being uncollectible from the insurance company and the full responsibility for payment falling upon the patient.

Children of Divorced Parents

Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Women's Health Specialists of Dallas, P.A.

Obstetrical Care Payments

When your initial appointment has been scheduled, we will research your insurance coverage (if applicable) and determine the estimated 'out of pocket' cost to you. A contract will be prepared, and reviewed with you, for the payment(s) that will be requested for your prenatal care and delivery. This payment schedule is expected to be honored by you.

Credit Cards

For your convenience, we accept Visa, MasterCard, American Express, Discover, and Debit Cards. Payments by credit card may also be made over the phone and online via our website www.whsdallas.com.

Return Check Fee

If a patient's check does not clear the first time, our bank will automatically put checks through a second time for processing. Checks that are returned to our office will carry a \$25.00 return check-handling fee. It is expected that the patients will pay the amount of the returned check and the fee with either cash or a credit card as soon as the situation is brought to their attention.

Appointment Fee

Your account will be charged a fee of \$25.00 for a missed non-procedure appointment or if you do not call to reschedule/cancel your appointment 24 hours before. If you are scheduled for an in office procedure then a fee of \$50.00 will be charged to your account if the appointment is missed.

FMLA, Short Term Disability, Long Term Disability and Verification of Physical Wellness Examination or Immunization Form Fees:

Your account will be charged \$25.00 per individual form.

Medicare

All of our physicians are not participating providers with Medicare. Please be aware that some office visits and/or procedures are not covered by Medicare on an annual basis. Please check with your local Medicare carrier for specific benefit guidelines. We do not accept assignment from Medicare; therefore payment is expected at time of service. We will file your claim with Medicare and you will receive their reimbursement.

Medicaid

We are not Medicaid providers. We will not file claims with Medicaid. Additionally, we are unable to accept Medicaid as a 'secondary' insurance.

Well-Woman or Annual Visits

Insurance companies will normally process these claims as 'preventative care'. Some insurance policies provide different coverage benefits for this type of visit. Although insurance claims will be submitted by our office for the visits, it is the patient's responsibility to understand and comply with their specific coverage benefits.

Well-Woman or Annual Visits...With a Medical Problem

The preventative visits are specifically defined by the insurance companies for their scope of treatment. As such, the reimbursement is limited for only those services authorized under that definition. Therefore, patients who receive the 'Well-Woman/Annual' visit **and** present at the visit for a separately identifiable problem that significantly exceeds the scope of the scheduled appointment, may also receive a charge for that additional visit and/or procedure.

Outside Services

Please be advised that patients may receive separate bills for any lab tests, pap smears, cultures and biopsies, as they may be sent to outside sources for analysis. Any inquiries regarding their charges should be made directly to that facility's business office.

Cash Patients

Payment in full for all services is expected at the time of service for patients without insurance coverage. Any exceptions to this policy must be arranged with our Business Office *prior* to the date of your visit. Additional charges could be billed to the patient if for any reason the laboratory has to run additional tests or screenings due to abnormal or reactive results.

Cash Discounts

Patients without insurance coverage *and* requesting consideration of a 'Cash Discount' will automatically receive a 30% discount on the billed charges for that day. In order to receive the discount, the full balance must be paid at the time of service.

Infertility Coverage

Most health insurance plans have very unique benefit structures for infertility coverage. If you have any questions about what your potential financial responsibility will be for your visit, be sure to consult your insurance company directly. But please be aware that because of inconsistencies in information received from the insurance carriers, our office is unable to verify and be held responsible for infertility benefit coverage details.

Medical Record Copies

Please be aware that there may be a minimum charge of \$25 for the first 20 pages of medical records, and .50¢ for each page thereafter. The charge depends on the amount of medical records needed.

Surgical Fees

During the scheduling process, our staff will estimate the 'out-of-pocket' costs for your scheduled procedure. Payment of this estimated amount is due prior to your surgery. This estimate, of course, will only include the cost of the WHSD physicians involved with the procedure (and exclude the facility fees, anesthesia, etc.). Subsequent to receipt of claims processing information from the insurance company, we will send you a bill for any additional funds due. Additionally, a refund will be processed timely in cases of an overpayment.

Billing Inquiries

Thank you for taking the time to understand our financial policies and the reasons behind them. If you have any questions or concerns about the financial aspects of your relationship with us, please feel free to contact our billing department at (214) 363-4421.

PATIENT NAME (PLEASE PRINT)

_____/_____/_____
(DATE OF BIRTH IN MM/DD/YYYY)

SIGNATURE OF PATIENT/GUARDIAN

_____/_____/_____
(DATE OF SIGNATURE IN MM/DD/YYYY)