

**WOMEN'S HEALTH PARTNERSHIP
MEDICAL GROUP**

168 North Brent Street, Suite 407
Ventura, California 93003

Patient Acceptance of Financial Responsibility

The practice of WHP Medical Group will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to WHP Medical Group. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to WHP Medical Group for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Interest charges from overdue patient due balances

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment and expedite payment for your services.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill your primary insurance only. If we do not receive payment within 60 days of the date that we bill your insurance, then we will transfer the balance to your responsibility and require that you remit payment to WPH Medical Group. To prevent this, we suggest that you stay in communication with your insurance company to assure that they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policyholders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement. If you would like to use a credit card for payment of your balance, please provide the following information. You will be notified in advance of charges made to your credit card.

Credit Card Type: Mastercard/Visa/Other _____ Card Number _____
Expiration Date _____ Name on Credit Card _____

All patient balances that are past due (greater than 30 days) will accrue an interest charge of 5% of your outstanding patient-due balance.

I understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay WHP Medical Group within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at the time.

Patient Printed Name

Responsible Party's Printed Name

Patient's Signature

Responsible Party's Signature

Date

Date