progressive care for women

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PROGRESSIVE CARE FOR WOMEN'S PAYMENT POLICY

I hereby acknowledge the following payment policy of Progressive Care for Women (PC4W):

1. Payment of copays, patient portions and balances due are expected at the time that services are rendered.

2. PC4W will submit a claim for the current services to your insurance carrier. When an insurance carrier is required to pay PC4W for a service that has been **provided, you are only responsible for what is considered the patient portion of the claim**. You are responsible for providing updated and accurate insurance information.

3. Our office requires a 48-business hour notice for all cancelations. If an appointment is canceled with less than a 48-hour notice, you will be charged $75 for an office visit or $100 for any procedure visit including ultrasounds. This will be processed immediately with the card on file.

4. **Our office does not send out billing statements. Your insurance carrier will send you an explanation of benefits (EOB), reflecting your patient portion. Your credit card will automatically be processed for your remaining patient portion two weeks from the date your claim was processed. A receipt will then be emailed. If your card declines, there will be a $50 charge added to your balance**

We strongly suggest that you monitor your account and the explanation of benefit forms that you receive from your insurer. You should resolve all disputes involving patient portions and explanations of benefits with your insurance carrier.

CREDIT CARD AUTHORIZATION

The credit card information will be stored in an encrypted PCI certified data base through JP Morgan Chase.
I hereby authorize PC4W to charge my credit card for outstanding balances, patient portions, any cancelation fees and/or no show, owed to PC4W, as provided in this Payment Policy.

Name of Patient: _____ D.O.B: __ __/__ __/__ __
Last First MI

Type of Card: Visa Mastercard AMEX Discover

Is this a Health Savings Account (HSA) or Flex Spending Account (FSA)? YES No

Email: _____

Card Number: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Exp Date: _____/_____ Security Code: _____

Billing Address: _____
Street Apt Number

_____
City State Zip Code

Name of Cardholder: _____
Last First MI

Authorized Signature: _____ Date: _____

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