FINANCIAL POLICY FOR NATURE COAST WOMEN'S CARE LLC

The goal of Nature Coast Women's Care is to provide you with the finest of medical care available at a cost that is both fair and reasonable. Your understanding of our financial policy is essential.

The following is our Financial Policy, which we require that you read and sign prior to treatment:

- **Self-pay** patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician.
- **Co-pays**
  The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a Financial Counselor. We accept cash, check, money orders or credit cards. Absolutely no post-dated checks will be accepted.
- **Insurance Claims**
  Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment. It is the patient's responsibility to understand his/her policy limitations.
- **Referrals:** If your health plan requires a referral or authorization from your primary care physician we will need to receive the authorization before you see our physician.
- **Copying medical records & Form Completion**: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your medical records, disability and other forms completed. Please allow a minimum of two weeks for copies to be ready. The clinic reserves the right to charge up to $50 per form/letter.
- **Return Checks:** A $25 service charge will be applied to your account for any returned check. If a check has been returned, we will only accept cash, Visa, MasterCard, and American Express.
- **Cancellations:** We understand that from time to time cancellations and rescheduling appointments occur. Due to the nature of our specialized practice we ask that you please allow our office at least 24 hour notice for cancellations and to reschedule appointments. Failure to do so may result in a no show fee of up to $50.00.
- **Minors:** The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.
- **Outstanding Balance Policy** It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at **2473 Care Drive, Suite 102 * Tallahassee, FL 32308**

I have read and understand the **Nature Coast Women's Care** Financial Policy. I agree to assign insurance benefits to the **Nature Coast Women's Care** Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative: ____________________________ Date: ____________