

# Gallatin Women's Center

## Financial Policy

Thank you for selecting Gallatin Women's Center as your health care provider. Our staff will be pleased to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician.

Co-payment for the services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, Visa, Mastercard, Discover, and Care Credit.

Due to varied contractual arrangements between lab companies and health insurance plans, please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan. Please remember your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory.

If you have insurance, we will make every effort to obtain reimbursement from that source, however, you will be responsible for any deductible, co-insurance payments, or co-payments. Please call our billing department if you have any questions.

Again, thank you for choosing Gallatin Women's Center. We appreciate the opportunity to serve you.

Signature of patient or guardian if patient is under age 18:

\_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

## No Show and Late Policy

We understand that there are times when you, the patient, must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment at least 24 hours prior, you may be preventing another patient from getting much needed treatment. Also, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. Therefore, if for any reason you do not show up to three appointments without calling to cancel, we may dismiss you from the practice.

We also understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Signature of patient or guardian:

\_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_