



Steven B. Powers, M.D., F.A.C.O.G.

George Rector, Jr., M.D., F.A.C.O.G.

Paul I. Lindner, M.D., F.A.C.O.G.

Rhonda J. Bertholf, WHNP, CNM, MSN

FINANCIAL POLICY

Thank you for choosing TotalCare For Women as your healthcare provider. We are committed to your health and well being and want your treatment to be successful. Please understand that payment of your account is considered an integral part of your treatment.

All patients must complete our electronic medical record *Patient Medical History* as well as our *Patient Registration Packet* before seeing the provider. We ask that you present your insurance card at each visit and notify us as soon as possible of any change in your insurance coverage, address and/or telephone numbers. We would like to keep your information as current as possible.

We are a specialist healthcare provider, therefore specialist co-payments & deductibles are due at time of service.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and AMERICAN EXPRESS

Your healthcare insurance coverage is a contract between you and your insurance company. TotalCare For Women will file your claims to your insurance carrier. Should your insurance carrier fail to make payment you will be responsible for the balance due. As providers we enter into contracts with healthcare insurance companies and are required to comply with their policies and procedures.

PARTICIPATION: Our providers currently participate with most insurance plans with the exception of **HEALTHKEEPERS BY PRIORITY (an Anthem HMO plan) AETNA HMO, TRICARE STANDARD AND TRICARE PRIME.**

NON-PARTICIPATION: If your insurance plan is one with which we are not a participating provider you will be responsible for payment ***in full at time of service***. We will provide you an itemized statement of charges and services provided in order for you to file a claim with your insurance carrier for reimbursement.

SELF-PAY: Payment ***in full*** is expected at time of service unless arrangements have been made prior to services being rendered.

PATIENTS COVERED BY HMO: Most HMO Plans require a (hardcopy) referral for specialist's office visits, diagnostic testing, physical therapy and most other specialty medical services. If one of our providers recommends, orders, prescribes or schedules any of these for you, you will be responsible for contacting your Primary Care Physician (PCP) and obtaining the necessary referral. With some insurance plans the obstetrician serves as the Primary Care Physician (PCP) for the duration of the pregnancy **ONLY**. In this case, your provider here at TCW would issue such a referral for those services deemed necessary.

NO-SHOW FOR APPOINTMENTS: A \$25.00 charge will be accessed on your account for failure to notify the office **24 HOURS** prior to your scheduled appointment time of your intent to cancel or reschedule. Messages left with our answering service less than **24 HOURS** prior to the scheduled appointment time will incur the stated NO-SHOW charge.

(PLEASE READ CAREFULLY AND INITIAL THE FOLLOWING:)

____ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are ***NOT*** a party to that contract. Our relationship is with ***YOU***, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances and "usual and customary" charges. As your OB/GYN healthcare provider we will supply factual information to facilitate claim processing. Also please understand we will not know if your insurance will cover your service(s) until the claim has been submitted.

____ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Unpaid balances may be subject to collection placement and collection fees. A \$35.00 service fee will be assessed for Returned Checks.

____ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty (60) days the balance will be due in full from you. If any payment is made directly to you for services billed by TotalCare For Women you recognize an obligation to remit payment to TotalCare For Women.

____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by TotalCare For Women, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

FINANCIAL AGREEMENT

I have read, understand and agree to this financial policy. In the event of non-payment by the insurance carrier for whatever reason, I understand that I am responsible for the payment of the balance owed, inclusive of all court costs and attorney fees of 33%. I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to TotalCare For Women.

Signature of Patient or Guardian

Date

Witnessed By

Date