Mid-Carolina Obstetrics & Gynecology
Since 1978

FINANCIAL POLICIES AND PROCEDURES

To Our Patients:
Declining insurance reimbursements as well as increasing paperwork required by insurance companies has caused an increase in our staff responsibilities, physician time and resources. We have found it necessary to impose the fees discussed below. These fees will not be billed to your insurance carrier and will be your responsibility. We are happy to discuss any questions you may have regarding these financial policies.

We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. These policies and procedures will establish the expectations you will receive from the WHA providers and also what we expect from you as our patient.

1. **APPOINTMENTS:** Please arrive 15 minutes prior to your appointment time. Failure to complete requested forms, patient portal documents or this Financial Policy form may subject you to reschedule your appointment.
2. **CO-PAYMENTS, DEDUCTIBLES, AND FEES:** Co-payment, insurance deductibles and fees for service, not covered by your insurance policy, will be collected at the time of service. We accept Cash, Visa, MasterCard and American Express. (NO CHECKS)
3. **INSURANCE:** Patients must complete and sign information/insurance forms prior to seeing the physician. A current insurance card must be presented at each visit, if not you will be responsible for payment in full at the time of the visit. You will receive a refund (within 45 days) upon payment by your insurance company. If WHA is not contracted with your insurance carrier, you are responsible for payment in full at the time of your visit. If your insurance company deems your visit a non-covered service, you will be responsible for payment in full.
4. **AFTER HOURS CONSULTATIONS/ PRESCRIPTION REFILLS:** For non-emergent issues we encourage you to utilize the patient portal found on our website at www.midcarolinaobgyn.com or you may call during regular office hours; otherwise a minimum charge of ($25.00) will be billed to you. Prescription refill requests need to be sent to the office through your Pharmacy.
5. **MISSED APPOINTMENT:** You (not your insurance company) will be charged ($25.00) for a missed appointment unless cancelled a minimum of 24 hours in advance.
6. **LAB BILLS:** If you have questions about your laboratory bill, please contact the lab directly.
7. **PAST DUE ACCOUNTS:** Payment is due when services are rendered. If we file your insurance claim and your carrier satisfies their responsibility, the remaining amount owed is your responsibility. You will receive three statements from our practice. In the event you have not paid in full or arranged and honored a payment plan within the three (3) months, we will refer your account to a collection agency. They in turn, will report your past due status to a Credit Reporting Agency. Any fees incurred by the WHA for Attorney or Court costs will be your responsibility.
8. **PREVENTIVE PHYSICAL VISITS:** Please be aware that most insurance companies cover one (1) preventive physical visit per plan year. Additional concerns or problems addressed at this visit will qualify as an additional problem visit and billed as such. There may be additional co-pays, deductible or co-insurance to address these additional concerns or problems at this visit. It is your responsibility to verify your benefits and financial responsibility before your appointment.
9. **COMPLETION OF FORMS:** A $20.00 fee will be charged as patient responsibility for completion of forms and must be paid prior to the release of the form These include but are not limited to: Disability, FMLA, and Leave of Absence, also Letters regarding flying and or airline tickets, coverage of Birth Control Pills, letters to employers and Merck Medco Rx forms.

This is an agreement between you, the patient, and **Women's Health Alliance, PA pka Mid-Carolina Ob/Gyn PC.** By signing this agreement, you agree to abide by all the policies and procedures stated within.

Patient's Name: _____ **Date:** ____/____/____

Signature of Patient or Responsible Party: _____

Witness Signature: _____