

Dear Patient of South Shore Women’s Health Care:

It is the policy of the practice that a patient responsible for all or part of her bill will receive financial information regarding all non-emergent services and surgeries prior to her appointment or surgery date.

If this office participates with your insurer you will be asked to present your insurance card at your appointment, to meet your deductible, pay your co-pay as determined by your insurance, be familiar with your insurance benefits that are not a policy benefit (i.e., preventative care, special test, etc, particular to your plan).

If this office does not participate with your insurance plan, this will not affect your relationship with your doctor. You can continue to see your provider of choice. We will bill your insurance company **ONE** time as a courtesy to you. Your insurance company will be instructed to reimburse you directly.

Surgery payments must be arranged prior to the scheduled surgery for non-emergent care. A surgical scheduling counselor will contact you to discuss your payment options.

Obstetrical patients will meet with an OB financial counselor to discuss OB payment options. Payments must be completed by 28 weeks gestation.

Payment in full is expected at the time of service. Our office cannot facilitate payments. For your convenience, we offer credit card options as well as payment by checks or money order. For patients who have **NO** insurance, a cash adjustment will be offered when full payment at time of service is made. As always, our mission is to provide excellence in medical care to our patients while maintaining fiscal integrity and fairness to our practice and its employees.

Acknowledgement of Financial Policy:

I understand and agree that I will be financially responsible for services provided to me by South Shore Women’s Health Care and all cost of collection incurred by the practice should my account be determined delinquent (approximately 40% of past due balance). I have provided the practice with all of my insurance coverage and will keep the practice informed if my coverage changes. I have read the information from South Shore Women’s Health Care regarding their policies on insurance billing, their participation status with carriers, co-pays and deductibles, and my responsibility for payment at the time of service. I have read and understand the policies and how they affect me and my financial obligations to the practice.

Date:_____Signature:_____

Release Authorization (PATIENT OR PERSON FINANCIALLY RESPONSIBLE)

I authorize the release of any medical information necessary to process my insurance claim. I understand that I am responsible for all charges not authorized by my insurance carrier.

Date:_____Signature:_____