

Northwest Gynecology Associates  
Financial Policy Acknowledgement

To avoid misunderstandings regarding remuneration for services rendered by our office, please review our financial policies as set forth below:

A health insurance policy is a contract between a patient, the patient's employer, and the insurance carrier. It is the patient's responsibility to verify services, providers and facilities eligible for coverage. We bill primary insurances as a courtesy to you.

1. We require your social security number,\* insurance card and complete demographic information for accurate submission of insurance claims.
2. You must notify the office of any insurance changes (loss of coverage, change in carrier, and changes in primary or secondary insurance status).
3. We have contractual relationships as a "preferred provider" with many carriers, and are bound by our contracts to collect co-pays and co-insurances. We are obligated to notify your carrier if you neglect to pay "patient responsibility charges." Failure to abide by your contract with your plan may result in immediate loss of health coverage.
4. Subject to a \$25 fee:
  - Insurance claims requiring resubmission due to inaccurate/incomplete information provided by patients.
  - **Each and all** "no show" appointments. A 24-hour cancellation policy is in effect.
  - Returned checks for insufficient funds.
  - Copies of medical records.
  - **Each** re-billing of a past due account.
5. We will make every attempt to assist you in successfully fulfilling your financial obligation to us. **All bills are due upon receipt.** Past due accounts will be subject to a \$25 re-bill fee. Delinquent accounts past 60 days will be transferred to a credit-reporting collection service. Once in collections, a \$75 fee is assessed in addition to any outstanding balance.

I have read this financial policy and understand that I am responsible for medical services rendered regardless of insurance coverage. If it becomes necessary to employ a credit-reporting collection service on amounts owed on this or subsequent visits, I am responsible for all costs and expenses, including reasonable attorney's fees. I hereby authorize you to release information necessary to secure payment and to have all insurance payments directly remitted to Northwest Gynecology Associates.

\_\_\_\_\_  
Signature of patient or parent/legal guardian

\_\_\_\_\_  
Date

\*Social security numbers enable us to extend you credit until your insurance pays for services rendered. A social security number is not required when agreeing to pay cash at each time of service.