ADVANCED WOMEN'S WELLNESS, PLLC

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We have developed financial policies to promote confidence and understanding between our patients and our practice. We are dedicated to providing the best possible care and service to you and regard a complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with a member of our staff.

- The patient is responsible for charges not covered or reimbursed by their insurance (including lab testing), with the exception of contractual adjustments mandated by your insurance company. Billing for lab work IS NOT included in your visit with us.

YOUR INSURANCE

- It is the responsibility of the patient to ensure she is seeing an in network provider. For plans that we are in network with, we file a claim and collect authorized copays, deductibles and coinsurance at the time of service.
- It is the responsibility of the patient to have their insurance card with them at the time of the visit and to notify the practice of changes in insurance coverage.
- If insurance cannot be verified at the time of the visit, the practice will collect in full for the visit.

CANCELLATIONS

- We understand that sometimes it may be necessary for you to cancel your appointment. Out of respect for our time and for other patients who may need an appointment, **we ask that give us at least 24 hours' notice when cancelling or rescheduling your appointment.** If you do not come for your appointment or give less than 24 hours' notice, **you may be charged a $35.00 cancellation fee.**

FORMS

- Any forms requested by employers for disability, FMLA, etc. need to have the patient portion completed prior to submission to us.
- There is a fee for forms completion that we require to be paid at the time we receive the forms. PLEASE ALLOW 7- DAYS FOR COMPLETION OF FORMS.

SURGICAL PATIENTS

- Surgery deposits are calculated based on information provided to us by your insurance company and are required to be paid in full by the time of the pre-operative visit.

MINOR PATIENTS

- Payment for services rendered to minor patients is expected at the time of the visit from the parent, legal guardian or the person accompanying the patient.

By signing below you are acknowledging that you understand this policy. You also authorize us to file claims for your services, collecting payment for those services and releasing information to your insurance company to assist them with payments of claims.

_____ _____ _____

Printed Name **Signature** **Date**

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