



FINANCIAL POLICY

We are committed to providing you the best possible care. In order to better inform you, Associates for Women’s Care has adopted the following financial policy. Please read and familiarize yourself with this policy so that future misunderstandings regarding our billing and payment policy can be avoided. If you have any questions, please do not hesitate to speak with our Financial Counselor or Billing Office.

1. We participate with most major insurance plans, including those listed below. If you are unsure whether your insurance is one with which we participate, please refer to the provider list supplied by your insurance carrier or call their member services. Please remember that you are responsible for any bill or portion of a bill that is not paid by your insurance company. Please note that if we do not participate with your insurance, we do not accept any fee schedule reductions and the patient is responsible for the full amount not paid by the insurance plan.

**Aetna
Bluegrass Family Health
CHA
United Healthcare
PHCS**

**Anthem Blue Cross & Blue Shield
Humana
Cigna
Medicare
Beech street**

2. We are obligated by contract to collect co-pays at the time of service, so please bring this with you. If your insurance card indicates that you do not have a co-pay it is our policy to collect a minimum of \$20.00 to go towards any co-insurance or deductible you may owe for the office visit. If your insurance pays for your visit in full any amount collected will be refunded to you. Please remember all co-pays are collected at the time of service, failure to have your co-pay will result in rescheduling your appointment.
3. Because of the many insurance plans on the market today, it is nearly impossible for us to stay well informed about each individual policy. It is your responsibility to know what your insurance will and will not cover and to ensure that your insurance company abides by the plan you have. We will file appeals and follow-up your claim as best as we can. However, if you are experiencing delays or difficulties with your insurer and the payment of benefits you should contact the Consumer Protection and Education Division of the Kentucky Department of Insurance at (800) 595-6053.
4. If you are pregnant, you will meet with at Financial Counselor et your first Prenatal visit. At that time she will review with you your insurance benefits. If your policy has a deductible and co-insurance you will be required to pay that in full at that time.
5. If you are scheduled for a Surgery or Procedure and have not met your deductible or co-insurance for the year, that remaining amount will be collected prior to your Surgery or Procedure date. If you have an outstanding balance on your account prior to the surgery or procedure you account must be paid in full. If you are unable to make full payment please speak to our Financial Counselor.
6. Mirena or Paragard IUD’s – If you have not met your deductible for the calendar year and your insurance plan states that the IUD will go to your deductible this must be paid up front before you receive the IUD.
7. HPV, Depo-Provera & Lupron Injections – If your insurance will not cover these types of injections or will apply the injection(s) to your deductible, we do require payment for the injection(s) at the time of service.
8. If you have no insurance, we require payment in full at the time of the visit, unless arrangements are made in advance. You will be asked to talk with our Financial Counselor and sign a payment agreement.
9. Effective April 16th, 2009 all unpaid/outstanding balances and payment plans will be charged an Annual Finance Charge of 18%. This is 1.5% monthly.
10. A service charge of \$25.00 will be assessed for each returned check. Checks returned for non-sufficient funds must be paid in full within 10 days or will be turned over to Fayette County Attorney’s Office and subject to applicable fees.
11. Past due accounts may be subject to attorney’s fees, court costs, and other cost of collection. In addition, failure to remit payment on a past due account may result in termination of physician/patient relationship.

Please remember: Your insurance is a contract between you, your employer, and your insurance company. You are personally responsible for any bill, or portion thereof, not paid by your insurance company.

I have read the above and understand my financial responsibilities in exchange for medical care provided by Associates for Women’s Care.

Name (Print) _____ Date of Birth _____

Signature _____ Date _____