NORTH VALLEY
WOMEN'S CARE

Financial Policy

Thank you for choosing North Valley Women's Care as your women's healthcare provider. We are committed to providing the highest quality of care to our patients. Your understanding of our Financial Policy and payment for services are important parts of this relationship.

INSURANCE: We will bill your insurance company for your medical visit and services; however, you should be familiar with your own insurance terms/ contract/coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not (copayments, deductibles, coinsurance, and other patient responsibility amounts). We cannot waive deductibles, coinsurances, or copays that your insurance requires. This is a violation of insurance rules. **Initial**: _____

To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, and any change of insurance information. You are responsible for promptly informing our office of any changes in patient information (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the bill being categorized as a patient's responsibility. Additionally, all copay's, coinsurance, deductibles and/or out of pocket costs are due before or in the service date. We have several options available for your convenience. **Initial**: _____

We accept most major insurance plans. However, with the frequent changes in the insurance marketplace, it is a good idea for you to contact your insurance company before your appointment and verify if we are a participating provider as per your plan. If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you could be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you. **Initial**: _____

REFERRAL/PRIOR AUTHORIZATION REQUIREMENTS: It is your responsibility if your insurance requires you to obtain a referral from your Primary Care Physician (PCP) for all specialty services. If a referral is not in place for your visit you will be responsible for the costs associated with the services provided. Our patients may require Prior Authorizations for injections, infusions, and medications. Patients must inform North Valley Women's Care if and when they have changes or additions to their insurance coverage, so that we can update any existing prior authorizations and properly bill for services. You acknowledge receipt of our financial policy and will be held financially responsible for any services your insurance company denies. **Initial**: _____

PATIENT RESPONSIBILITY: All copayments, deductibles, patient responsibility amounts, and past due balances are due at check-in unless previous arrangements have been made with our business office. Although we may estimate what your insurance plan may pay, the insurance plan makes the final determination of your eligibility and benefits. **Initial**: _____

PATHOLOGY/LAB SERVICES: You may receive an additional bill from the lab service provider based on your clinical needs during your appointment. All questions about these fees must be directed to the lab service provider. **Initial**: _____

NON-COVERED SERVICES: You must understand whether or not any services will be covered. The patient or the patient's legal representative is responsible for all charges for services rendered. "Non-covered" means a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment. **Initial**: _____

I have read, understand, and agree with the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by North Valley Women's Care to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate North Valley Women's Care to extend credit to me for the services provided.

Please sign and date, acknowledging that the above policies have been read and understood. Please see the front desk if you have questions about any of these policies.

Patient Name (Printed): _____ **Date of Birth**: _____

Patient Signature: _____ **Date:** _____