New Life Women's Health
Financial Policy and Patient Responsibility

We are committed to providing our patients with the highest quality care.
Thank you for taking the time to read and understand our policy.

As the patient I understand and agree to the following responsibilities:

 To know their insurance policy. Patient's should be aware of their benefit coverage prior to their appointment regarding such items as contracted physicians with their plan, covered and non-covered benefits, authorization requirements, deductibles, coinsurance and co-pays. We recommend you contact your carrier directly with any questions pertaining to your coverage.

 To obtain a referral from their Primary Care Physician (PCP) prior to receiving services if one is required. Any non-covered services are the financial responsibility of the patient

 To pay their co-pay, deductible and coinsurance at the time of service.

 To promptly pay any patient responsibility indicated by their insurance carrier.

 To pay any balance due as a result of non-disclosure of any health insurance coverage.

 To facilitate claims payment by contacting their insurance carrier when claims have not been paid.

 To understand that as a courtesy, NLWH will file claims with a secondary or tertiary insurance carrier one time. Payment and/or follow up on balances due by a secondary or tertiary insurance are the patient's responsibility.

 To be held responsible for any return check fees.

 To cancel an appointment at least 24 hours in advance. Failure to notify our office within the 24 hour time period may result in the assessment of a no show fee of $25.

 To pay a $25 administration fee or to make an appointment with the provider, when requested by the provider, for the completion of forms such as FMLA, Disability and other forms requiring manual completion. Payment is required in advance and is not billable to your insurance carrier.

 To pay a $25 collection fee if your account is sent to a collection agency.

New Life Women's Health may release any information regarding my medical condition and treatment to my insurance company. I assign all insurance benefits to NLWH. I understand I am responsible for any/all charges and I agree to pay any balance deemed not covered or patient responsibilitu by my insurance company. This authorization will remain in effect until revoked by me in writing.

I have read and understand the above financial policy. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

Patient Name (Please Print):_____

Signature: _____ Date: _____