BAYSIDE WOMEN'S HEALTH
FINANCIAL POLICIES/TREATMENT CONSENT

Thank you for choosing our practice. Our providers appreciate your trust in us and the opportunity to care for you. As a part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy and treatment consent. Please sign it prior to any treatment.

FINANCIAL POLICY

Payment is due at the time of service. Co-payment and Deductibles are a contract responsibility between the patient and their insurance company and are non-negotiable as we are required to collect them.

Insured Patients: As a courtesy to you, we will bill your insurance with a copy of your current insurance card. Fees for non-covered services will be collected at the time services are rendered. After receiving your insurer's explanation of benefits (EOB) statement, if there remains an amount due, we will require that it be paid within 60 days. If your insurance coverage should change during the course of treatment, you should notify Bayside Women's Health immediately.

Uninsured Patients: Patients without medical insurance coverage should expect to pay for their treatment in full at each visit. If charges exceed what you can reasonably pay at that visit, please speak to the Front Office Manager to make arrangements for the balance. All uninsured patients are billed based on our Self Pay Fee Schedule. Our Front Office Manager will design a payment plan for you, based on our criteria and your ability to pay. All charges must be paid in full unless you have a signed payment plan. Delinquent accounts that are turned over to outside collections will be charged the full fee for all services.

Pregnancy Related Fees: Fees for pregnancies can vary widely depending on the patient's specific insurance plan. Therefore, Bayside Women's Health may review these fees with you during your 1st trimester. We will inform you in writing of any deductibles, co-insurance and co-pays. The 1st half of the deductible will be due prior to your 20 week ultrasound appointment and the remaining balance due by your 32 week appointment. There may be a time that your insurance does not cover all the care that you receive even though your physician believes it is medically necessary. In these instances, the charges will be reviewed with the physician in an effort to receive payment through your insurance provider. If the charges are still considered non-covered the balance will be released to the patient.

Procedures and Surgeries: Our Front Office team and/or Nurse Manager will provide a Financial Estimate for procedures and surgeries. This will be determined by looking at co-insurance and deductibles on each individual policy. ALL fees (i.e., co-pays, deductibles) will be required before any elective surgery or in-office procedure. A fee of $25 will be incurred for any changes you request within 2 weeks of surgery. Failure to give proper notice of cancellation of your surgery will result in the following fees:

- $100.00 7 days prior to surgery
- $250.00 5 days prior to surgery
- $500.00 48 hrs or less

Outside Pathology or Laboratory Services:
If expertise of an outside lab is needed for a portion of your care, you may receive a bill from that lab for their services.

Delinquent Accounts: Your account will be reviewed if payment is not received after 60 days and will be considered delinquent. We reserve the right to send delinquent accounts to a collection agency. If that is the case, you will be responsible for any costs in connection with collection of a delinquent account. Collection agencies typically charge a 30 – 40% fee of the balance on the account. Non-payment of a delinquent account could affect your ability to schedule future appointments at Bayside Women's Health.

Additional Charges: Returned checks for NSF, Stop Payment, or Account Closed will be subject to a $35.00 fee.

No Show Charge: Any appointment must be cancelled or rescheduled 24 hours or more in advance or a $25 NSF will be charged to your account and must be paid prior to rescheduling.

Change of address: Please update personal information with the business office. If a change of address cannot be found and a statement is returned by mail, the account will be turned over for collection.

TREATMENT CONSENT

Telephone Consent: I give consent to be contacted on my wireless phone number (call or text) regarding billing, collections, and appointment reminders.

Assignment of Benefits: I assign payment of authorized insurance benefits otherwise payable to the policyholder or beneficiary, including without limitation Medicare, Medicaid and Tricare, directly to Bayside Women's Health for any services furnished to me. I further assign to the physician(s) who provide services or their authorized representative(s) such benefits payable for physician/s services.

Authorization for Release of Information: I authorize Bayside Women's Health to release any medical and billing information including but not limited to the following:

a. Insurance Billing – information requested by the insurance company or other third-party payers to support the claim submitted for payment of charges applicable to this account.

b. Medical Necessity and Appropriateness of Services – information requested by any utilization and/or peer review organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of this account or to determine benefits for related eservices. This release allows disclosure about the treatment, diagnostic testing or other medical information including psychiatric, alcohol, HIV, drug abuse and /or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. That revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

Treatment Consent: I hereby authorize the doctor and the associates/assistants of his/her choice to treat my condition. I understand that possible risks are present in any treatment or procedure that may be performed, and that my physician will explain these prior to initiating any treatment or performing any procedure. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me. I agree that Bayside Women's Health can request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: My signature authorizes that I have read the above and understand treatment consent and the financial policy. I understand that it is my responsibility to notify Bayside Women's Health in writing of any changes to this release of information consent. I acknowledge that I have read and understand the Notice of Privacy Practices and that I can obtain a copy upon request. I understand further that Bayside Women's Health and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are the policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by my signature below, indicate that I DO NOT OBJECT to such communications.

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Patient Name (printed) Date

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Signature of Patient