# WINCHESTER WOMEN'S SPECIALISTS

## FINANCIAL POLICY

Thank you for choosing our Practice as your healthcare provider. We are committed to providing you with the highest quality of care. You should understand that timely payment of any bills is necessary. **Please review and sign below.**

- All co-pays and deductibles are due at the time of service. If you are uninsured, we expect full payment at the time of service. Payment plan options should be discussed with us prior to the date of service.

- We will ask that you update your individual information each time you are in the office so that we can ensure timely correct billing. Your signature below indicates your willingness for us to communicate with your insurance carrier for the purposes of verifying benefits and submitting insurance billing.

- If your insurance terminates while we are providing care, you will be responsible for all bills.

- We require that you give us 24 hour notice of appointment cancellation, or accept that we will charge you for a repeated history of missed appointments.

- Services performed outside of the practice are billed separately by the provider of these services. These services may include: certain lab testing, hospital facility charges, and mammography readings. We use BioReference Laboratory for lab tests we do not do here, who will send you a separate bill as necessary.

- There is a charge of $20 per disability form and/or FMLA form completed by our office. Payment is due when you give us the form. You should expect five (5) working days for completion of these forms.

- Our rates and services are usual and customary for our geographic area. We accept cash, personal checks, VISA, MASTERCARD and DISCOVER. There is a $50.00 fee for returned checks.

- Failure to pay your bill in a timely manner will result in our terminating our physician/patient relationship and we may transfer your account to an outside collection firm. Should we have to proceed with collection efforts, you will be responsible for any costs charged to us by our collection agents, attorneys and the Virginia Court System.

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**I have read this Financial Policy and agree to these terms.**

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PATIENT SIGNATURE DATE

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PRINT NAME

_____ _____

GUARDIAN SIGNATURE DATE

Rev. 2012,2014