CENTER FOR WOMEN'S HEALTH FINANCIAL POLICY

Payment may be with: Cash, Check, VISA or MasterCard.

If you do **not** have medical insurance, payment **in full** is expected at the time of service. We will accept payment for your treatment directly from your insurance company for the amount they state they will cover.

You are responsible for providing our office with your **correct, current** information. If you give us incorrect information at the time of service, a **$10** fee will be charged to resubmit the claim.

Fees not covered by insurance are your responsibility. If you are using your medical insurance, you must present your card **prior** to being seen.

You may **not** pay with cash or credit card, and then expect us to file to your medical insurance at a later time.

YOUR OFFICE CO-PAY MUST BE PAID IN FULL BEFORE YOU ARE SEEN.

A parent who brings a minor child to our office for medical care is legally responsible for payment of all of her charges.

An administration fee of **$10 per form** is charged for all forms: Disability, Maternity, FMLA, etc. This fee is due at time of request. Forms will **not** be completed without payment.

Even though you may have medical insurance coverage, **you** are ultimately responsible for payment of your account. Insurance arrangements are between you (the insured) and your company.

This office makes **no** guarantee of benefits. Any quote of benefits provided by your insurance company is considered a general overview, and only a **guideline** until payment is finally received. All benefits are subject to review when the insurance company receives the actual claim form.

A **$30** fee is charged for **returned checks**, and a **Rebilling Fee** of **$5 per month** is added to all past due accounts.

AUTHORIZATION FOR TREATMENT AND SERVICE, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND CHARGE TO MY CREDIT OR DEBIT CARD

I hereby authorize medical treatment for myself (or, my dependent) as deemed necessary by H. Hodes, MD, T. Nauser, MD or C.O'Donnell, ARNP.

I also authorize Hodes & Nauser, MD's, PA and its designated employees, to furnish information to my insurance company and other medical professionals regarding treatment or services provided to me (or, my dependent), and regarding my medical condition or that of my dependent.

I hereby assign to: Hodes & Nauser, MD's, PA any and all payments made for medical treatment or services provided to me or, my dependent**.**

I understand and agree that I am ultimately responsible for payment of ALL charges rendered by H. Hodes, MD, T. Nauser, MD or C.O'Donnell, ARNP for such medical treatment or services whether or not such charges are covered and paid (either fully or partially) by my insurance company.

OFFICE CREDIT/DEBIT CARD POLICY

I understand it is the policy of Hodes & Nauser, MD's, PA to secure an imprint of my credit or debit card at the time of my visit.

If, after a claim has been submitted to my insurance carrier**:**
(1) the claim is denied for any reason; **OR,**
(2) the charges are not paid (**or** only partially paid) by my insurance carrier;

Hodes & Nauser, MD's, PA will then charge my credit or debit card for the **entire amount** owed for treatment or services provided to me or my dependent.

I understand that in the event my credit or debit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment to Hodes & Nauser, MD's, PA for those charges, the office will issue a **credit** to my credit or debit card in the amount received from my insurance carrier.

CARD: CREDIT / DEBIT *(CIRCLE ONE)*   **VISA MasterCard** *(CIRCLE ONE)*

Card Number: ________________________________

Expiration Date: ____________ **Security Code:** ________

Name of Card Holder: ________________________________

Signature of Card Holder ________________________________

Name of Patient: ________________________________

Address: ________________________________

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Telephone No: _______________

I hereby authorize Hodes & Nauser, MD's, PA (a Kansas corporation) and its designated employees to charge my credit or debit card the full amount of all charges made for medical treatment and services provided by Hodes & Nauser, MD's, PA and the amount charged to my credit or debit card will be reflected on my credit or debit card statement. The charge will be based on the medical treatment rendered to me (or, my dependent) and the usual and customary charges made by Hodes & Nauser, MD's, PA for such treatment and service.

If payment is denied by my credit or debit card company, I will pay the entire amount within 30 (thirty) days.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by H. Hodes, MD, T. Nauser, MD or C.O'Donnell, ARNP, and agree that if the office places my account with an agency or attorney for collection, Hodes & Nauser, MD's, PA shall be paid by me for **all** of its costs and expenses in collecting monies owed to them to the extent allowed by applicable law. Those expenses include, but shall **not** be limited to, attorney's fees, court costs and other expenses incurred with collection of my account by an agency or attorney.

This authorization shall remain effective unless expressly revoked by me **in writing**, delivered to the offices of Hodes & Nauser, MD's, PA at: 4840 College Boulevard, Overland Park, KS, 66211-1601.

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SIGNATURE of Patient/ Responsible Party

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PRINTED Name
DATE: ___________________

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