MT HOOD WOMEN'S HEALTH
FINANCIAL AGREEMENT

Welcome to MT. HOOD WOMEN'S HEALTH, PC. We're glad you've chosen us to provide you with your health care. We are an organization that is dedicated to the practice of medicine, specializing in obstetrics and gynecology. We charge fees that are usual and customary for our area.

Your health insurance policy is a contract between you and your health plan. Please understand our office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Whatever the outcome of your insurance claim, you are responsible for payment of your account. Please take time to review your health insurance policy. **If you have questions regarding your coverage, benefits or preferred facilities, please call your insurance company**. Our office deals with many different insurers and we do not have first hand knowledge of your benefits. Health insurance trends are toward higher patient **Co-insurance and Deductibles** which means greater out-of-pocket costs for patients. Collecting past-due accounts are an extra cost in operating a medical office. We collect these at the time of your visit because our costs, and therefore your costs, are substantially increased when bills are not paid promptly.

The following is a statement of our Financial Agreement which we ask that you **read and sign**:

PAST DUE BALANCES, COPAYS & PRE-ARRANGED DEPOSITS ARE DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, MONEY ORDERS, AND VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER CARD.
WE OFFER A BUDGET PAYMENT PLAN WITH PRIOR APPROVAL

We will bill your insurance plan. Our practice has contracts with such plans as Medicare, Medicaid, health maintenance organizations and a number of preferred provider organizations. If we are not contracted with your health plan, we will send your claim to them as a courtesy to you and we will send you a statement. If your non-contracted plan has not paid our office within 45 days, **we will transfer the responsibility of the bill to you.**

Please come prepared to pay Co-payments, Deductibles and Past Due balances at the time of your visit. Some health plans require a 30% Co-insurance which could result in a substantial increase in your out-of-pocket costs. If you have a co-insurance of 30% or more, a high deductible plan ($1,000 or more) or an HSA and we are unable to determine your remaining deductible, or if you have no health insurance you will be asked for a deposit on your out-of-pocket costs. Please plan to pay at least $100 for each office visit and diagnostic test at the time of service if your deductible or co-insurance is described above. Depending on services provided, your deposit could be higher.

For services not covered by insurance, we offer a cash discount. (This does not apply to medications or IUDs.) The fees must be paid the same day services are rendered in order to receive the discount. If your visit is related to an on-the-job injury or a motor vehicle accident, we will require a valid insurance company and claim number or payment in full at the time of your visit for the services we provide you.

Please be aware there is a possibility that some or perhaps all of the services provided may be non-covered services or may not be considered medically necessary by your health plan. If you receive a service your health plan does not cover, we will request payment in full from you at the time you receive the service. Some health plans require a referral from your primary care physician prior to our doctors treating you. **Please make sure you obtain a referral if your policy requires this.** We will ask you to sign a waiver stating that you will pay for services if your health plan does not cover them.

Budget Payment Plan

Special arrangements may be made for patients having more costly office or hospital procedures. We understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay your balance in a limited number of monthly installments. Our Billing Office can assist you with these arrangements.

I have read, understand and agree to this Financial Agreement.

x____________________________________ ____________________
Signature of Responsible Party Date

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Please print name