Camelback
Women's Health

FINANCIAL AGREEMENT

By placing my signature on this page, I agree to the following:

- I am consenting to treatment and services ordered by my Physician or Nurse Practitioner to be performed by Camelback Women's Health and/or it's associates.
- I understand I am financially liable for all services performed, including those, which, are not covered by my health insurance company or if my coverage is not effective at the time services are rendered.
- I understand I am responsible for confirming and understanding my insurance company's coverage limitations and policies, including my obligation for deductibles, co-insurance, and co-payments.
- I understand any referrals or authorizations needed for the visit or services to be rendered are MY responsibility to obtain prior to my visit. I realize I may not be seen if these are not in place or I accept full responsibility for payment.
- I authorize my insurance company to make payment directly to Camelback Women's Health for services provided.
- I understand all payments are due at the time of service, including co-pays, deductible balances, and co-insurance.
- I understand and agree to pay $25 fee for all returned checks.
- I understand any returned checks are subject to further collections by the County Attorney's office if I do not forward payment upon request.
- I agree if my account is turned over to an outside collections agency for non-payment, to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the collection agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action become necessary to collect on the outstanding account balance, I agree to pay attorney's fees and court costs incurred for collection. I understand any outstanding bad debts, which I am not making consistent monthly payments for will be reported to the national credit reporting agencies/bureaus.
- I authorize Camelback Women's Health to disclose all or part of my medical and/or financial records to my insurance company or third party payor, which may be needed to assist in payment of services rendered per HIPAA regulations. This may include utilization review organizations, hospital, or medical service companies, governmental agencies, or the employer for the insured (for self-funded plans only). I understand this may be revoked by me in writing at any time, except to the extent to which action has taken in reliance upon it. The authorization will stay in effect as long as the need for information exists.

I understand and I agree to the above mentioned:

Signature: _____ Date:_____

Signature of Parent or Guardian, if applicable: _____