Camelback Women's Health

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Camelback Women's Health ("CWH") as your healthcare provider!

The medical services you seek here imply an obligation on your part to ensure payment in full is made for services you receive. This **Patient Financial Responsibility Agreement** will assist you in understanding that financial responsibility.

Consent. I consent to treatment and services ordered by my Physician or Nurse Practitioner at CWH and/or its associates. I understand my healthcare provider may perform medically necessary services, as well as 'elective' services, according to current standard of care guidelines. I do have the right to consider or decline services prior to them being performed. My consent to undergo such treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

Responsibility. I understand I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance or any other patient responsibility amounts indicated by my insurance carrier or for any services not covered by my insurance.

Insurance Policy. It is my responsibility for knowing and understanding my insurance policy, both the coverage benefits and policy limitations. I understand I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilize my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Payment Arrangements. Whether or not I have insurance or are self-pay, payment of my account balance is due within thirty (30) days of receipt of my billing statement. I understand if I need to make special payment arrangements, I may contact the Patient Accounts Staff to arrange a mutually agreeable payment plan. I agree to make monthly payments on this plan until my account is paid in full. If my account is over ninety (90) days past due, my account will be in default and may be referred to a collection agency.

Payments Accepted. I understand I can make payments by check, cash, money order, debit cards or credit cards (Visa, MasterCard, American Express or Discover), or via PayPal.

Payment by Check. If my check payment is returned or declined for any reason, my account will be charged a surcharge of $35.00 in addition to any costs assessed or charged by the bank. Checks returned to the office are also subject to further collections by the **Maricopa County Attorney**'s office unless a valid method of payment is forwarded upon request. After two (2) returned checks have been received by CWH, my personal checks will no longer be accepted and I will be responsible for using another method of payment.

Ancillary Services. I may receive ancillary medical services while a patient of CWH such as anesthesia; interpretation of tests; imaging services (e.g., ultrasound and mammogram); diagnostic testing, etc. I understand some physicians may not provide services directly in my presence, but are actively involved in the course of my diagnosis and treatment. I authorize payment directly for these services under the policy issued to me by my insurance carrier. I may incur additional charges as a result of ancillary services. I agree to pay all remaining charges for services after benefits paid on my behalf are credited to my account as determined by my insurance carrier.

Collection of Anticipated Charges. For maternity care/services, office and surgical procedures, CWH will collect my anticipated financial responsibility for such services prior to delivery for prenatal care; and prior to delivery or prior to scheduling an office or surgical procedure. CWH will contact my insurance carrier to determine an estimate of the anticipated amounts owed based on the current contracted amounts and fee schedules. I will not hold CWH responsibility for incorrect/inaccurate information provided by my insurance carrier regarding my insurance benefits or benefit plans. CWH does not accept responsibility for incorrect information given by me or my insurance carrier regarding my insurance benefits or benefit plans. If an account balance remains due after the claim has been processed and amounts collected for anticipated charges have been applied, I understand I will be held responsible for the remaining amount and am ultimately responsible for payment

Non-Payment on Account. Should collection proceedings or other legal action become necessary to collect my overdue or delinquent account, I understand CWH has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) a $50.00 collection agency fee will be added to outstanding balances placed with a collection agency; (iii) Interest of 10% per year will be accrued on the principal balance placed with the agency; (ii) all attorney/court costs and fees incurred in the collection process; and I acknowledge that if my account is referred to a collection agency, legal representative, court, or when the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history. Once my account is placed with a credit/collection agency, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at CWH as a result of my account being sent to a collections agency.

Minor Patients. The patient/guardian presenting with a minor for care is the responsible party for payment of the minor's account balance regardless of the responsibility judgment between parents. CWH will not act as administrator to resolve my financial agreements. According to state law and in certain situations, a minor can seek and will be provided treatment in CWH offices without parental consent or knowledge. Minors can choose to utilize their insurance coverage provided by their parent for claims submission or they can choose to be self-pay. Depending on the circumstances of the visit, CWH may or may not share information upon parental request. State law allows minors the right to patient confidentiality under certain circumstances.

Authorization to Contact. I authorize CWH personnel to communicate with me by mail, answering machine messages, and/or e-mail according to the information provided in my patient registration information and my patient portal setting preferences. CWH, or any agent or servicer of my patient account, may use any information I have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact me for purposes related to my health and my account, including debt collection. I authorize CWH to use this information in any manner consistent with the information I have provided, including mail, telephone calls, e-mails, or text messages. I expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages.

Acknowledgement. I understand I am ultimately responsible for payment for the services I receive at CWH, regardless of my health insurance coverage. I understand CWH will not act as administrator to resolve my personal financial agreements in regards to my medical care. I have had the opportunity to read this financial statement in its entirety and have had the opportunity to ask questions regarding the details of this statement. Any questions have been answered to my satisfaction.

I consent to and agree to the aforementioned policies of Camelback Women's Health's and understand they may be changed without notice.

_____ _____

Patient Name Date

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Signature

Please refer to our website at www.camelbackwomenshealth.com for additional information regarding our financial policies.

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