WOMENS GROUP OF FRANKLIN, PLLC
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FINANCIAL POLICY

We are committed to providing you with the best possible care. It is the expectation that all patients receiving services are financially responsible for the timely payment of all charges Incurred. If you have medical Insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy.

Please carefully read the following financial policy and provide your signature indicating your understanding and acceptance of this policy.

INSURED PATIENTS

We participate with many major Insurance carriers; please check with our office staff to verify our participation with your plan. Patients who are insured through participating Insurance companies will be billed according to policy/contract requirements.

Current copies of your Insurance card must be on file in our office In order for us to file your insurance. Periodically, we will request an updated photocopy of your card. Please remember to notify our office If your insurance has changed or is terminated.

Deductibles and co-payment must be paid on the day services are rendered.

We are happy to file your Insurance claim for you. Please remember that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure; others pay a percentage of the costs.

SELF PAY

Payment Is due at the time services are rendered unless prior arrangements are approved, in advance with our Office Manager. We accept cash, personal checks, Visa, Mastercard or money orders/cashier's checks.

REFERRALS

Many Insurance plans require referrals for some visits and not for others. Take the time to team the requirements of your Insurance plan. Patients are expected to obtain the appropriate referral from their Primary Cara Physician (PCP) prior to services being provided. Failure to provide the necessary referral may result in payment denial by the Insurance carrier and services provided will become the payment responsibility of the patient.

LABORATORY AND ULTRASOUNDS

Laboratory (blood work), Pathology (reading of the pap smear) and ultrasounds provided by Maternal Fetal Medicine are completely independent of Dr. Ellington and Dr. Scott. You will receive bills for these services from the providers as the services are rendered.

NON-COVERED SERVICES

ANNUAL EXAMS/PHYSICALS

Services for Annual Exams/Physicals are required to be billed as preventive care and may not be covered by your insurance company. Some carriers will deny services for an Annual Exam If the exams occur within a 12 month period, resulting in services provided becoming the responsibility of the patient for payment. Please check with your carrier for specific guidelines.

Patients presenting with medical problems during appointments for an Annual Exam may be billed for an office visit In addition to the preventive care.

If you are experiencing medical problems, please notify our office staff so they can schedule your visit appropriately to Insure proper Insurance reimbursement.

CONTRACEPTION

All contraceptive devices (IUD) furnished by the office are to be paid tor at the time service is provided. Some Insurance carriers will reimburse for visits to manage contraception and supplies while others do not. Check with your Insurance carrier for benefits specific to your plan.

INFERTILITY

Patients seeking Infertility services must furnish a statement from their insurance company regarding Infertility benefits before service is rendered. All services not covered by insurance must be paid for at the time of service.

WORKER'S COMPENSATION

Patients will be responsible for services provided due to automobile or work Injury, involving a third party. As a courtesy, we will be glad to file Insurance for you.
Please be prepared to provide information relating to your place of employment, names of supervisor and/or human resources director, time and place of the accident or injury and cause of accident or injury.

CHILD CUSTODY

Payment for services rendered is the responsibility of the person seeking treatment or the person seeking treatment for a minor. Court decrees for custody and financial responsibility is between the individuals involved without the inclusion of our office.

RETURNED CHECKS

There will be a $25.00 service charge on all returned checks.

OVERDUE BALANCES

Accounts uncollected by our office may be turned over to an outside collection agency or collection attorney. In this event, payment in full will be required for any future services, regardless of insurance coverage. You will also be responsible for any court costa, attorney fees or other fees incurred by the agency to collect your account.

I, _____, have read and understand the above financial policy and will comply.

Patient Signature: _____ Date: _____

Parent or Guardian if under 18: _____ Date: _____