



### **Women's Health Care Specialists Financial Policy**

*Thank you for choosing Women's Health Care Specialists for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.*

*Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient.*

*Your health insurance policy is a contract between you and your health insurance company. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre- authorizations. You should be knowledgeable of any deductibles, copayments, and/or coinsurance.*

*If you are uncertain, about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits.*

#### **Insurance Coverage**

*Please provide us with your current insurance card at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy and keep on file in our records. Failure to provide complete insurance information may result in patient responsibility for the entire bill.*

*Please be aware of and provide any required referrals or authorizations in advance of the appointment. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.*

*Our doctors belong to many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care.*

*Although we may estimate what your insurance company may pay, it is the insurance company that makes the final Determination of your eligibility and benefits. Any amount quoted by us is just an estimate. Once the claim is filed and processed, you may owe more or less than originally quoted. In this event, you agree to be responsible for any additional cost. WHCS will refund the patient any overpayment after the claim is completely process if needed.*

#### **Addresss Change**

*It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.*

#### **Co-payments/Co-insurance e/deductibles**

*You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service. We will also collect all previous outstanding patient balances at the time of your visit.*

### **Women's Health Care Specialists**

7525 Greenway Center Drive, Suite 202, Greenbelt, MD 20770  
Phone: - 301-459-4317, Fax: 301-798-5009

6355 Walker Lane, Suite 303, Alexandria, VA 22310  
Phone: - 571-316-2954, Fax: 571-316-2952

URL: <https://www.whcsmd.com>

e-mail: [service@whcsmd.com](mailto:service@whcsmd.com)



### Other Bills

You may receive services at Women's Health Care Specialists or by our physicians in another location that will result in separate billing such as radiology, pathology, laboratory, surgery, deliveries, hospitalizations or other services. We do offer in-house laboratory services by Quest and LabCorp Diagnostics. This is a separate service and all lab work, pathology, and biopsies may result in a separate bill from Quest or LabCorp.

In addition, you may receive inpatient or outpatient hospital care at associated Hospital. If so, you will receive a hospital bill for those services.

### Payments

All co-payments and past due balances are due at the time of service. We accept cash, check and credit cards (VISA, MasterCard and American Express.) Payment in full is required for any elective procedures and/or services. If you are unable to pay the full amount at the time of service for non-elective services, please speak with us to arrange acceptable payment arrangements.

We will bill your insurance. Once they have paid, you will receive a bill for the remaining amount owed. The balance is due in full within 30 days of receipt of the statement. If you are unable to pay the full amount within 30 days, please call the number located on your statement to make payment arrangements.

We require patients to provide a credit card to be kept on file for balance less than \$150.00. Once your insurance company processes your claim any remaining balance less than \$150.00 will be billed to the credit card on file. If an amount above \$150.00 is due, you will receive a courtesy phone call before payment is processed. No credit card information will be retained in our office and is handled by a secure company.

A credit card is required to be kept on file for any payment arrangements agreed to as well.

It is important that you update any credit card on file information as needed to insure proper payment of your balance with our office. You are also encouraged to retain a copy of your transaction receipt.

### Self-Pay

Self-pay accounts are patients without insurance coverage and patients covered by insurance plans in which the office does not participate. It is your responsibility to know if our office participates with your plan. Self-pay patients are required to pay for services in full at the time of service.

Self-pay patients paying in full, utilizing our credit card on file option and/or maintaining a payment agreement will receive a 20% discount. In the event a credit card is not chargeable or a payment agreement becomes void due to nonpayment a discount will no longer be applicable.

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### Non-Covered Services

Medicare patients may not cover some services your doctor recommends and will not cover yearly physicals done in our office. You will be informed ahead of time and given an Advance Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully. Medicare will cover a physical done in your primary care provider's office (i.e. Family Practice, General Practitioner, Internist, etc.) Any Medicare patient that would prefer having a yearly physical done in our office, which includes a breast /pelvic exam and pap smear, will be required to pay \$100.00 at time of service. After Medicare and any secondary insurance has been filed, the patient will receive either a bill for the remaining patient responsibility or a refund for the amount paid by the patient at the time of service.

Non-Medicare patients are responsible for payment in full at time of service for any service not covered by their insurance plan. If unable to pay in full, please speak with us to arrange acceptable payment arrangements.

### Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be eligible for collection activity (which may include a collection agency), or attorney, and possible discharge from the practice. Any fees incurred by the practice in order to collect an outstanding debt may be the responsibility of the patient.

Payments and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.

### Non-Medical Fees

Additional fees may apply to the following:

**Returned Checks** – There will be a \$25 fee assessed on returned checks. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash/money order only basis following any returned check.

### Patient Credits and Refunds

In the event a patient payment results in an overpayment or "credit balance" on your account, the overpayment will be refunded to the patient as soon as all payments posted to the account have been verified and any unpaid dates of service have been resolved. Refunds are sent on a monthly basis via check.

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Assignment of Benefits and Responsibility to Pay

*I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to Women's Health Care Specialists, for medical services to myself and/or my dependents. I have also read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.*

Date: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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