Financial Policy

Welcome to Estrella Women's Health Center. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office financial policies.

We will bill insurance claims as a courtesy to our patients provided we have your current information and any necessary referrals. Should your insurance require a referral and we have not received it prior to your appointment, you will be responsible for payment in full at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Each insurance plan is different and has its own policies on what is and is not a covered benefit. While we do make efforts to verify coverage under your plan, it is ultimately your responsibility to know what is covered and which benefits fall under your plan. It is also your responsibility to verify that our providers are in your network.

The laboratory company is a separate entity and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. We ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. We reserve the right to dismiss patients from the practice if they have a pattern of missing appointments without notification.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence and/or phone number.

I have read the above Financial Policy. I understand and agree to these terms. _____

(Please initial)

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Estrella Women's Health Center. _____

(Please initial)

Release of Information

I authorize my Personal Health Information to be disclosed as specified below:

Primary Number: _____ Acceptable to leave a message on this number: YES NO

Secondary Number: _____ Acceptable to leave a message on this number: YES NO

To the following family member(s) or other person(s):

_____ / _____ / _____

Name Relationship Phone Number

_____ / _____ / _____

Name Relationship Phone Number

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient/Guardian Today's Date