ARIZONA WELLNESS CENTER FOR WOMEN
AOA family of obgyn physicians
www.aoafamily.com

Financial Policy

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.

_____
(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

Financial Policy

Thank you for being a valued patient. Please take a moment to read and sign our policies.

Insurance/Financial Policies

- We are contracted with most insurance plans. These plans may have a co- payment or deductible. We expect co-payment at time of service. Payment plans for non-covered services can be arranged through our billing office.
- Each insurance plan is different and has its own policies on what is and is not a covered benefit. It is your responsibility to know what is covered and which benefits fall under your plan.

__Initial

Delinquent Accounts

- Account balances should be paid within 30 days of the account statement.
- Outstanding balances after 90 days will be transferred to a collection agency unless prior arrangements have been made with our billing office.

__Initial

Cancellation of Appointments/No Show

When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment.

- If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of $50.00.
- A no show occurrence may be subject to a $50 charge for an office visit and/or ultrasound visit. There may also be $100 charge for procedures and/or surgeries.

_Initial

Returned Checks

- There will be a $25 service fee for any check returned for insufficient funds.
- After two returned checks we will no longer accept checks as your form of payment.

_Initial

Concerns

If you have any concerns regarding our office, please feel free to speak to our office manager so that we may address any issues.

I have read and understand the above policies.

_____ _____

Patient Signature Date