

Welcome to Southeast Women's Center

Welcome and thank you for choosing Southeast Women's Center as your healthcare provider. Our mission is to provide a comfortable and professional atmosphere along with excellent patient care.

FINANCIAL POLICY

Insurance Policies:

We will, as a courtesy, file insurance claims that we participate with on your behalf. Please note that if your insurance company fails to pay your claim within a timely manner it will become your responsibility.

Secondary claims will be filed once and we will only file to those carriers we participate with. All co-pays are due at the time of service. OB patients having coinsurance will be expected to pay this amount by their 28th week of pregnancy.

Self Pay:

You will be considered a "Self Pay" patient if you do not have insurance or carry an insurance we do not accept. GYNS: Will be required to pay a \$200.00 deposit for your first visit and can make a payment agreement for your balance not to exceed 90 days. OB's will be expected to pay \$3183.00 before their 28th week of pregnancy. A 20% discount will be given if this amount is paid, in full, at the OB work up visit. All payment plans must be current with our office.

No Show and Cancellation Policy:

We will assess you a \$30.00 "No Show" fee if you fail to notify our office 24 hours in advance of your circumstances.

Return Check Charge:

We will assess you a \$25.00 return check fee for any NSF checks written to our office. You will need to use a credit card or cash at your future visits with us.

Medical Records/Disability/FMLA:

We will charge you for your medical records according to the North Carolina Statute. There will be a \$25.00 charge for all medical forms.

HIPAA:

Due to the Health Insurance Portability and Accountability Act we will not disclose your PHI (Protected Health Information) to anyone other than; yourself, coordinating care providers, hospitals and your insurance carrier. If you wish or do not wish to consent another party (spouse, parent, etc.) to receive this information please fill in the statement below. (This would allow us to leave a message regarding your PHI with a designated individual.)

I consent _____ to access my PHI.

I understand that I am responsible for all non-covered services and payment of charges is due at the time of service. I hereby give consent to Southeast Women's Center to provide whatever treatment the assigned physician/provider may deem medically necessary on my behalf. I release my insurance benefits to be paid directly to the physicians at Southeast Women's Center. I have read and acknowledge this financial policy.

Signed: _____ Date: _____