COMPASSIONATE CARE FOR WOMEN

FINANCIAL POLICY

I understand it is my responsibility to check with my Insurance Company, in advance, to verify that Compassionate Care for Women is contracted provider within their network. I understand that it is my responsibility to know the benefit plan provisions of my policy. If a referral is required, I am responsible for obtaining it from my primary care provider. I understand that it is the policy of Compassionate Care for Women to collect any co-payment, coinsurance, share of cost, and/or deductible amounts at the time that service is rendered. I understand that it is my responsibility to inform Compassionate Care for Women of any social and/or insurance demographic changes at the time of service.

Pap Smears and Labs:

Pap Smears and certain tests are sent to Independent Laboratories for analysis. You may receive a bill from the Laboratory for these services. The fees will vary depending on what test were performed.

Vaginal Cultures:

I understand that vaginal cultures may be necessary to evaluate or to treat my medical condition and/or symptoms. I also understand that cultures can include testing of bacterial and yeast infections as well as venereal diseases, including Chlamydia and gonorrhea. I acknowledge that these cultures will be performed if the doctor or nurse feels that they are necessary in evaluating my condition, and that they will be performed on all pregnant patients as required by the hospital. Further, I understand that my insurance may cover all, part, or none of the costs of these laboratory tests, and I will be responsible for the co-payment, coinsurance, share of cost and/or deductible as determined by my insurance.

_____ **YES,** I agree to have a vaginal culture performed.

_____ **NO,** I decline to have a vaginal culture performed.

Cancellation and No Show Appointments:

To cancel a scheduled appointment, Compassionate Care for Women requires 48 hour notice. If 48 hour notice of cancellation is not provided, or you no show for the appointment, you will be charged $80.00.

Lab Returned Check:

If a check is returned from your bank, you will be charged a fee of $25.00. If more than one check is returned, we will no longer accept checks from you as payment.

I have read, acknowledge, and agree to the above stated terms. My authorization will remain in full force and effect until I revoke it in writing.

Responsible Party Signature: _____ Date: _____

Patient Name: (please print): _____