

|                             |  |          |               |          |             |
|-----------------------------|--|----------|---------------|----------|-------------|
| Print Name                  |  | Age      | Date of Birth |          |             |
| Mailing Address             |  | City     | State         | Zip Code |             |
| What county Do you live in? | Occupation   | Employer |               |          |             |
| Social Security Number      | <i>Please Check if it is ok to call or if we need to be discreet</i> |          | OK to Call    | Discreet | Emerg. Only |
| Email Address:              | Home Phone   |          |               |          |             |
|                             | Work Phone   |          |               |          |             |
|                             | Message Phone  |          |               |          |             |
| Emergency Contact's Name:   | Emergency Contact Phone  |          |               |          |             |

### FINANCIAL POLICY

We want to thank you for choosing us to provide your health care. We appreciate your trust in us and the opportunity to serve you. We have determined from the information you provided us that your payment method is as follows. Please read the marked section(s) and sign below.

**PRIVATE PAY**

**If you are not using a third party health plan**, the fee for services has been determined by our sliding fee scale which is based on your annual income. Our sliding fee scale groups many services into one fee, as is the case with other abortion services. It is one flat fee whether or not you need/want IV or IM therapy, ultrasound, pregnancy testing, Rh testing, Rhogam and/or other items. (Infrequently, you may require additional services such as an outside lab or non-routine prescription medications that are not included in the flat fee and you may be charged extra.) A receipt of how much you paid for a group of services will be provided to you. This is a special grouped fee that cannot be itemized or processed by an insurance company.

**THIRD PARTY BILLING**

**We cannot bill for your services unless you give us correct coverage information.** You must make sure to give us complete and accurate information. If your health plan sends you any type of questionnaire regarding multiple health plans, eligibility, or requests a signed claim form, respond as quickly as possible. They are waiting for that information before making payment on services.

**Payment arrangements may be necessary if you owe money or if you overpaid us.** We will send a billing statement to your address if there is a balance owing or we will send a refund check if you overpaid us. You may make special arrangements with our billing department to not send a statement to your address by providing us with an alternate address. You should make payment arrangements on remaining balances within thirty days of the clinic's billing date to avoid further collection action from us. We are **VERY** flexible in making your payment arrangements so please stay in touch.

**Confidentiality cannot be guaranteed when a third party resource is used.** We make every effort to insure your confidentiality. Our policy states that no information regarding services received at our facility will be given to anyone without your permission. However, if you are using a third party to pay for your services, you are giving us permission to give information to that company. Be aware that even though you have made special arrangements with us for your mail, the company or agency paying for your services may send mail to your address.

**Your account may be referred to a collection agency,** if you provide us with false or fraudulent information or withhold information to us or your health plan (including address and phone numbers) that results in non-payment to us, or if you cash a check that was meant for us, or if we are unable to contact you. Confidentiality cannot be guaranteed by the clinic on accounts referred to a collection agency.

**Non-Contracted Insurance Plans** – We may accept assignment of benefits. Accepting assignment of benefits means that we will bill your insurance company our "usual and customary" fee for the services you receive here and we expect the benefit payment to be paid directly to us. The charges to your insurance company are itemized and we will bill for services actually provided. The balance of your account is your responsibility whether your insurance company pays us or not. Be aware that some, and perhaps all, of the services we provide you may be non-covered services or may not be considered reasonable and necessary by your health plan. These amounts would be your responsibility. Your insurance coverage is a contract between you and your health plan. We are not a party to that contract. We will collect from you a percentage of your charges not covered by your health plan and any unmet deductible. We will estimate those amounts when we pre-verify your insurance coverage. Co-pays and deductibles are due prior to services.

**Participating Provider Plans or other Contracted Insurance / Agencies** – We may have an agreement/contract with your health plan and/or other agency for providing some services. These health plans have agreed to pay us a pre-determined amount and/or percentage for providing those services. We will collect from you whatever co-payment our contract or agreement stipulates. Each agreement is different, dependent on the type of coverage you have. In some cases we may not be permitted to collect anything from you. Co-pays and deductibles are always due prior to services.

**I have read the sections marked above. I fully understand, and agree to, this Financial Policy.**

Client Signature

Date