ARTEMIS Maternal and Fetal Medicine

FINANCIAL POLICY - CONSENT AND UNDERSTANDING – ASSIGNMENT OF BENEFITS -- HIPAA

Thank you for selecting Artemis for Women, LLC, for your specialty care. We do our best to ensure you and all our patients have an active role in their care, and we strive to make every visit meaningful. The highest quality of care is our goal.

Please review this policy and sign a copy for our records, so that you have had an opportunity to understand your responsibilities. If you have any questions, please ask a staff member.

Orders and referrals:

Our practice is specialty and provides advice to your obstetrician, midwife, or family physician to help you receive the very best care during or before your pregnancy. We are not able to see patients without a referral from a physician, and for patients having an ultrasound, there are **absolutely no exceptions. If we have not received an order from your physician or midwife, we cannot perform a diagnostic ultrasound.**

Insurance participation:

You are responsible for determining your individual and specific insurance benefits, including whether our practice is in-network or out-of-network. If we are out-of-network, you will be required to pay in full at the time of services, and then you may file your claim with your insurance to reimburse you according to your plan. **It is your responsibility to verify your benefits with your insurer, including to verify which procedures and services are not covered by your plan.** _____ initial

If you have a non-Medicaid insurance, that insurance will be billed as your primary. Failure to give correct insurance information may fall into the territory of fraud and may result in immediate termination of our treatment of you in this office. _____ initial

Payment for services:

Please plan to bring your identification, your current insurance card, and a form of payment for any specialist co-pays to each visit. _____ initial

If you have insurance, we will file a claim to your insurance company as a courtesy. This claim will request payment for all covered services that you receive in our office to be paid to Artemis for Women, LLC. **You will then be responsible and billed for any allowable balance that was not paid to us by your insurance company.** _____ initial

Please be aware that for most of our patients, you will not have met your deductible for the year by the time you come to this practice. If you have not met your deductible, **the total amount due will be collected on the date of service** and the claim will be sent to your insurance company to be applied to your deductible. We offer a substantial discount to patients who pay in full and then who file their claim to their insurance themselves. We will be happy to give you the information your insurance company needs to reimburse you appropriately. If after your insurance has processed your claim, you still owe a balance, we will send you a bill. If after your insurance has processed your claim, you have overpaid, we will issue you a refund.

If you have no insurance coverage (“self-pay”), you will be responsible for payment for all charges on the date of service. We understand that the cost of health care is expensive, and offer a discount for self-paying patients. If you acquire insurance coverage after your visit, you may submit your claim from the services provided by our office and seek coverage yourself.

If you are having difficulty with your payments, our billing service can help you from having your account go into collections. If you have insurance and your insurance does not pay for your services in a timely fashion, **we may send the bill to you to pay**, Medicaid

and some HMOs being exceptions. We are not a bank or a credit service, and we will not harass your insurance for payment. We are a medical office and we see patients. **Your bill is your responsibility.** _____ initial

If you have a balance due from a previous appointment, the amount due must be paid in full prior to being seen by the doctor at your next visit. If you are unable to pay in full, you may still be seen if you have a standing payment plan in place. _____ initial

If you are unable to make payments, we will put you in contact with our billing company to discuss options for payment. We accept major credit cards, personal checks, and cash. We would prefer you to not use cash but will accept it if no other form of payment is available.

Missed appointments and late cancellations:

We reserve your appointment time for you to have the care you deserve. **If you are unable to come to your scheduled appointment, please notify our office 24 hours in advance**. We will be happy to reschedule you for another date, and we will be able to give another high-risk patient your appointment time. It is our policy to charge **$45 for missed appointments**, and this charge is not covered by insurance. _____ initial

If you cancel your appointment on the same day as you are scheduled, we will not be able to give your appointment time to another patient. These **late cancellations may be subject to a $45 fee**. _____ initial

Collections:

If you do not pay your account, you will be responsible for any fees that may be associated with efforts to collect what you owe. TransWorld Systems will contact you and have their own charges. All patients in default will be sent to collections and will result in damage to your credit score and financial record.

HIPAA:

Please review the written HIPAA policy (separate form). Signing below acknowledges that you have been given information regarding your privacy rights. _____ initial

*I have read and understand the above financial policy. **I realize that I will likely be paying something at the time of each visit**. I understand that my insurance company will be billed for services and payment will be sent to Artemis for Women, LLC. I understand that I am ultimately responsible for any payment not covered by my insurance. **I accept my financial responsibilities as a patient of Artemis for Women, LLC, and agree to be treated.** I have also received a copy of HIPAA policy. Failure to adhere to these policies may result in termination from our practice.

_____ _____
Signature of Patient or Responsible Party Date of Birth

_____ _____
Mobile Phone Today's Date

_____ _____
E-mail Emergency Contact Name and Phone

Office use only: Patient number: _____ EDC: _____
Updated 9/17/2018

Amy Rouse-Ho, MD 2600 Roosevelt Road, Suite 2006, Valparaiso, IN 46383 Phone (219) 615-0095 - Toll free (844) 573-6959 - Fax (317) 350-1379