Patient Financial Agreement Form

Welcome to South Lake Women's Health, P.C. Our professional staff is committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to receiving treatment.

Authorization

I hereby authorize the release of pertinent medical information to my insurance carriers, and I agree to assignment of benefits to the physician. I am aware that the health insurance coverage varies and, while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the physicians of South Lake Women's Health, P.C. and any other charges for laboratory fees, radiology fees, and any other fees as a result of the treatment rendered. If I have insurance that the doctors are contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company.

Finance Charges

I understand and agree that there will be a late fee added to my account if I fail to pay within thirty (30) days from my first statement. The late fee charge will be $25.00. I understand that I am solely responsible for this late fee and that it will not be billed to my insurance.

I understand that a finance charge will be imposed for patient due balances after January 1, 2004, which has not been paid within 30 days of the time of service. The finance charge will be computed at the rate of one percent (1%) per month unless alternate arrangements have been made.

Returned Checks / Clerical Fees

I understand that if the bank returns a check there is a $29.00 processing fee that will be added to my account. I understand and agree that I will be billed $1.00 for the first 10 pages and $.50 for 11-50; $.25 for pages 51 and higher.

Late Cancellation / Missed Appointment

I agree to pay a fee of $25.00 if I fail to either cancel an appointment 24 hours prior, or fail to show up for a scheduled appointment.

Attorney Fees

In the event that I fail to pay the balance of my account to South Lake Women's Health, P.C. within sixty (60) day of the date of service, my account will be turned to collection. In the event that it is necessary to turn my account over to collection I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

Authorization & Release

I have read and fully understand the Patient Financial Agreement as outlined above. I have also been given a copy of the Patient Financial Agreement for reference.
I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.

_____ _____

(Patient Signature) (Date) (Patient Printed Name) (Date)