OFFICE PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other Gynecologists and Obstetricians in the Yakima area. We ask for payment at the time of service. This includes payment for the office visit, procedures, and any tests that are performed. We commonly require payment at the time of check-in.

Any laboratory tests which require an outside lab company to perform will be billed separately by that company.

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to Yakima Women's Health, PLLC. **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan. Prior to any procedure, we may assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the procedure. We accept Cash, Checks, Visa, Master Card or CareCredit.

You are responsible for your co-payment, deductible, or other non-covered services as set by your insurance carrier. Non-covered services, co-payments and deductibles are collected at the time of service. **If your insurance carrier requires a referral number to receive services from our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit**.

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

***Monthly statement fee of $4.00 on any unpaid balances over 60 days** _____(Patient Initials)

***No Show Fee: $20.00** (Your insurance will not pay for this) _____(Patient Initials)

***Require $150.00 down payment for office procedures and $300.00 for Hospital surgeries**
_____(Patient Initials)

***Unless prior payment arrangements are made, Account Balances are due in full within 30 days.**
_____(Patient Initials)

CONSENT TO TREATMENT AND PRIVACY

I authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physician at Yakima Women's Health, PLLC including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I have read and understand the above policies and consent to treatment.

_____ Date: _____

Patient Signature

Print Name: _____ Relationship to Patient: _____