WOMEN'S CANCER CENTER

Financial Policy

Thank you for choosing WOMEN'S CANCER CENTER as your healthcare provider. We are committed to your treatment being successful. Our Billing Department will work hard to make sure your claims are filed accurately and promptly. Please understand that insurance reimbursement can be a long a difficult process. Therefore, it is important for you to understand YOUR insurance policy and coverage. **Please read and initial the following**

_____ Women's Cancer Center will submit a claim to your insurance company as a courtesy to you. If we are NOT Contracted Providers with your insurance company, your out of pocket expenses WILL be more. It is your responsibility to find out from your insurance company if we are In-Network Providers.

_____ All co-pays and/or co-insurances are due at the time services are rendered. These payments must be collected prior to you leaving our office. Our office must stay in compliance with federal law which requires us to collect all co-pays and co-insurances to the best of our knowledge.

_____ I have received and signed the **Anti-Kickback Form** and the **Assignment of Benefits Form**.

_____ Not all services are covered by your insurance company; please refer to your policy for clarification and verification of coverage and benefits. Fees for non-covered services are the responsibility of the patient or guarantor.

_____ We do NOT bill secondary insurances UNLESS Medicare is your primary or Medicare, Tricare or Medicaid is your secondary insurance.

_____ If we do bill your secondary insurance and your secondary does NOT cover the entire balance left by your *primary* insurance you are responsible for the difference between the two. We base your responsibility on your primary insurance's allowed amounts.

_____ Fees for lab work or cultures are billed separately by the appropriate lab. Women's Cancer Center is not responsible for any outside billing facilities.

_____ If your insurance company changes, it is your responsibility to notify us immediately so that we may bill correctly. If you give the NEW insurance information after services are rendered and we are denied for timely filing, you WILL be responsible for any charges.

_____ If your insurance company does not pay your claims within 90 days, we reserve the right to begin billing you directly. We recommend that you contact your insurance carrier to follow up on the payment status. Accounts become delinquent after 120 days and will be placed with a private collection agency and subject to a $25 collection fee and all costs associated with the collection process.

_____ Returned checks will be subject to a $25 fee. Payment for the returned check must be paid by cash or with a credit card. You will NOT be seen again until the fee is paid.

_____ If you do not call and cancel/reschedule your appointment within 24 hours of the appointment time, you will be charged a $25 NO SHOW FEE.

_____ I have read the financial policy, I understand and agree with this financial responsibility.

_____ _____

Patient Signature / Responsible Party Date

_____ _____

Print Patient Name / Responsible Party Date

Updated 1/2014

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurances or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier. If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum has not been correctly calculated. Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws. We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Date_____

_____

Patient or Guardian Signature

_____

Name Please Print

Administrative and Research Office
3131 La Canada Str., Suite 110
Las Vegas, NV 89109
Phone 702.693.6870
Fax 702.693.6899

University of Nevada School of Medicine
Division of Gynecology and Obstetrics
2040 W. Charleston Blvd., Suite 200
Las Vegas, NV 89102
Phone 702.671.2300

I, _____, understand that services rendered to me by Women's Cancer Center are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Women's Cancer Center and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENTOF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company. I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also understand that should my insurance company send payment to me, I will forward the payment to Women's Cancer Center within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable. To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Women's Cancer Center to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____

Signature of Patient or Guardian

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Women's Cancer Center of Nevada