LARAMIE PHYSICIANS FOR WOMEN & CHILDREN PAYMENT POLICY

Thank you for choosing Laramie Physicians for Women & Children. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. Insurance. LPWC contracts with most major insurance companies, with Wyoming Medicaid and Medicare, and with selected other qualified third-party payment sources. However, LPWC does not contract with all third-party payers.

- **a.** If you are insured by a plan LPWC contracts with you will be expected to pay your entire co-payment, an estimate of your deductible or the co-insurance portion of your charges, **on the day of service**. Co-payments, co-insurance and deductibles are part of your contract with your insurer. LPWC will file an insurance claim directly to your insurance company.
- **b.** Payments collected at the time of services are estimates, based on the information available to LPWC at that time. If there is an additional balance due after your insurance has paid then the balance will be your responsibility. Payment in full is due upon receipt of a billing statement.
- **c.** If you are not insured by a plan we do business with, payment in full is required at each visit.
- **d.** If you don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage.
- **e.** Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage.

Initials:_____

2. Updates. Our staff will ask you to verify your insurance information, address and phone number at ***each and every visit***. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

3. Coverage changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

4. New Patients. Insured patients seeing us for the first time (patients must have seen a LPWC provider at least once in the last three years to be considered established) will be required to pay a minimum of 30% for any appointment other than OB care and wellness. Non-insured patients will be required to pay in full at time of service.

5. Non-covered services. Some and perhaps all of the services received may not be covered by your insurance or not considered reasonable or necessary by your insurer. "Non-covered" may become your financial responsibility and payment in full for these services is generally due at each visit.

6. Nonpayment. If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account.

7. Payment plans. Contact one of our Billing Specialists if you need to review your financial status or make payment arrangements. Any payment plans agreed to may include a monthly interest charge.

8. Payment Methods. LPWC accepts payments via cash, check, Master Card, Visa and Discover Card. Payments can also be made online at **Laramiephysicians.com/our-office/billing-insurance**

9. Missed appointments. You may be charged for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time. Help us to serve you better by keeping your regularly scheduled appointment.

10. Returned checks (NSF). You will be charged a $30.00 processing fee for any personal check returned for nonpayment.

By signing this form you authorize LPWC to release the necessary information in order to complete and process your insurance claims.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Please complete additional information on back of form