2015 Insurance & Payment Policies

Billing→Other→2015 Financial

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

We are committed to providing you with the best possible care and believe that a clear understanding of our Payment Policies is important. Please complete this entire form and ask us any questions about our fees and your financial responsibility before receiving any healthcare services. Completion of this form is necessary if you would like Women's Health to bill your insurance company **or** if you would like to apply for a discount.

☐ 1 **I don't have insurance and I would like to find out if I am eligible for insurance or a discount.**
If you are eligible for health insurance we ask that you meet with our enrollment specialist prior to receiving services. Please present proof of income along with this form. Some services are not available at a discount without income verification.

☐ 2 **I have health insurance that Women's Health accepts and I request that you bill my insurance company directly.**
Co-pays and deductibles or coinsurance prepayments may be required. It is your responsibility to verify with your insurance company that we are an in-network provider for your specific plan, if applicable. Ask us if we currently accept your health insurance.

☐ 3 **I have health insurance, but choose not to use it.**
Please present proof of income along with this form. Depending on the services that you are requesting, you may be eligible for our sliding fee scale**.** Because of funding limitations, many services are not available for fee reduction without income verification. If you are between the ages of 18 to 26 and are covered under your parent/guardian's insurance, let us know if you have concerns about confidentiality.

☐ 4 **I prefer not to declare my income or use my insurance. I agree to pay the full rate for all services.**
Payment is due at the time of service. We are able to offer a "pay today" discount for most services.

☐ 5 **I have health insurance and I plan to bill them myself.**
You agree to pay the entire cost of the services you receive today. We will charge you at our "pay today discount" prices and provide you with a summary of charges. You can then file a claim with your insurance company, who will process the claim directly with you.

☐ 6 **I don't want my parent(s)/guardian to know I receive services here and I am 17 years of age or younger.**
Women's Health keeps any and all information about you and the services you receive here strictly confidential as required by law. If you are accessing abortion care, the State of Colorado requires parental notification, however there are exceptions that may apply. Please ask a staff member if this is an issue for you.

Payment for services:

Payment is expected at the time of service, including co-pays, and deductibles. Accepted methods of payment include: Cash, Credit Cards (Visa, MasterCard or Discover), Checks (for some services) and money orders. If you pay by check and the check is returned for insufficient funds, an additional $20 service charge will be added to your balance.

Please document all sources of income so that we can make sure that you are not overcharged.

Are you employed? No ☐ Yes ☐ Occupation: _____

Personal income: Hourly rate $_____ average hours worked / week _____ **or** Annual salary $_____

Partner/spouse income: Hourly rate $_____ average hours worked / week _____ **or** Annual salary $_____

I have the following additional income:

- ☐ Unemployment benefits
- ☐ Parental or Family Support (for rent, bills etc.)
- ☐ Savings/Inheritance
- ☐ Child Support/Alimony
- ☐ Disability or Social Security
- ☐ Other _____

How many people, *including you*, are supported by your household income? _____

Quarter 1 2 3 4 Verified by: _____

Calculated personal income: _____ month / year

Calculated partner income: _____ month / year

Additional income: _____ month / year

TOTAL INCOME: _____ month / year

Income Level 1 | 2 | 3 | 4 | 5 | Insured

Verification? Yes No _____
(type of verification/reason)

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Insurance:

If you are using insurance, be aware that complete confidentiality of information related to your visit cannot be assured. This is because a statement of your services will normally be sent to the insurance carrier and to your address on file with the insurance company. If you want these statements to go to a different address, it is your responsibility to contact your carrier directly. If you have a balance after we have billed your insurance, we will send a statement to your address.

Many insurance companies have limitations that may affect your coverage. It is your responsibility to know what healthcare services are covered by your particular insurance policy. This includes requirements and policies regarding: referrals, prior authorizations, co-payments, co-insurance, deductibles and benefits. Questions about your coverage should be directed to your insurance plan administrator. **The staff and providers at Women's Health do not know what is or isn't covered under your specific plan.**

You are required to pay your co-pay at the time of service. We may also require you to pay a portion of your deductable or co-insurance if your insurance company says that you owe one. After we bill your insurance company, you are responsible to pay any amount not covered by your insurer. If your insurance carrier denies your claim, you will be responsible for your account balance in full.

Please Initial Below:

_____ I request and assign all payments of authorized benefits be made on my behalf to Boulder Valley Women's Health Center (BVWHC) for any services that I receive. I authorize BVWHC to file appeals on my behalf for any denial of payment.

_____ I understand that not all services are covered under all health plans. **If my health plan does not cover a service or procedure, or if my visit is subject to a deductible or coinsurance it is my responsibility to pay for those charges**. During the course of your care we may recommend additional tests or services—these may result in additional charges.

_____ I understand that some routine screenings, including but not limited to: contraceptive management, urinalysis and certain injections may not be covered by some insurance carriers. **I understand and agree that I will be responsible to pay for services that are not paid by my insurance company.**

_____ I understand that all outside lab charges (blood work, cultures, biopsies and pathology) are not included with my office visit and will be billed to my insurance separately by the laboratory. The laboratory will bill you/your insurance according to its fee schedule which Women's Health has no control over. Women's Health is not responsible for these charges.

Please fill out the following information about your insurance policies. Present your insurance card to the front desk at each visit.

Primary Insurance Company name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose insurance policy is it?: ☐ Mine ☐ Parent's ☐ Spouse/Partner ☐ Guardian ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: XXX-XX-_____

Address: _____ City: _____ State:_____ Zip: _____

Secondary Insurance Company name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose insurance policy is it?: ☐ Mine ☐ Parent's ☐ Spouse/Partner ☐ Guardian ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: XXX-XX-_____

Address: _____ City: _____ State:_____ Zip: _____

ALL PATIENTS, SIGN BELOW:

Your signature indicates that you have read and agree to the above financial policy. You are certifying that the information you have provided is accurate to the best of your knowledge.

Printed name: _____ Signature: _____ Date: _____

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