



Women's  
Institute  
for  
Specialized  
Health, PLLC

## FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost effective manner. However, the ability of W.I.S.H. to achieve this depends greatly on your understanding of our financial policy. IF you have medical insurance, we will file insurance claim forms on your behalf. We do this as a courtesy to our patients and are anxious to help you receive the maximum allowable benefits from your insurer. Even though we will file insurance claims for you, we need your active participation in the insurance claims process.

**Commercial Insurance Patients:** Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. We review our charges annually to assure that they are within usual and customary limits of most commercial carriers. Commercial insurance patients should be prepared to pay a minimum of 20% of their bill at the time of service.

**HMO / Managed Care Insurance Patients:** Many HMO / Managed Care Plans require that you obtain a referral in order to receive care from a specialist. It is your responsibility for obtaining this referral if required. Unauthorized services will be the financial responsibility of the patient. Please have your referral forms and membership card handy when you check-in. You will be required to pay the co-pay for authorized services at the time of services.

**Patients with No Insurance:** Generally, patients with *no* insurance are required to pay for their visits in full at the time of service. If special financial arrangements are deemed necessary, you will be given information regarding who to contact at the time of your visit. It is imperative you follow these instructions immediately to satisfy your financial responsibility with W.I.S.H.

We accept cash, checks and Visa, Mastercard and Discover payments.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_