Lynette Stewart, M.D., F.A.C.O.G.; Beenal Naik, M.D., F.A.C.O.G;
Yun Mei Fung, M.D.; E. Nicholas Gilbert, M.D.; Tonia Stevenson, CNM, MidWife

PATIENT FINANCIAL AGREEMENT

I agree that in return for the services provided to me by Georgia Center for Female Health, I will pay my account at the time services are rendered. If co-pays and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Georgia Center for Female Health. All co-pays and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, it may be turned over to a collections agency.

NON-COVERED SERVICES

I understand that Georgia Center for Female Health contracts with healthcare service plans (i.e. HMOs and PPOs) that relate only to items and services which are "covered" by the healthcare service plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the healthcare service plans not to be covered. Examples for non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a healthcare service plan or in the benefit summary of the healthcare plan furnished to the patient.

HMO REFERRALS

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If the authorization is not provided you will be asked to either reschedule your appointment or pay for your visit at the time of service.

SELF PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the practice does not participate in or patients without an insurance card on file at the time of service. The undersigned agrees that I am individually obligated to pay the full charges at the time of service.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate in are considered self pay accounts. It is your responsibility to inform us of any changes with your insurance carriers, to confirm the practice's participation, and your eligibility prior to each visit. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Georgia Center for Female Health if I belong to a plan in which Georgia Center for Female Health does not participate.

RETURNED CHECKS

All returned checks will be assessed a $35.00 fee.

_____

Name (print)

_____ _____/_____/_____

Signature Date

_____ _____/_____/_____

Witness' Signature Date