Augusta Women's Health and Wellness Center
WE CARE FOR YOU – MIND AND BODY

Donna Adams-Pickett Ph.D., M.D.
Obstetrics and Gynecology

Financial Policy Statement and Agreement

Patient Name: ______________________________ Date of birth: ______________

Basic policy pay for service is due in full at the time service is provided in our office.

For patients with insurance we bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayment and deductibles are due upon your visit. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Please be advised that we will do everything possible to receive payment from your insurance carrier.

Medicare patients we will bill Medicare for you. We will also bill secondary insurance carrier for you. All co-payments or deductibles are due and pay able at the time service is provided. All Medicaid, Medicare, and private insurance patients must provide a. current ID card at the time of visit.

Non- covered services: Any services not paid for by your existing insurance coverage will require payment in full.

Yearly health checks periodic preventive health checks may or may not be covered under your health insurance policy; however, your physician may require them. If you agree to have a non-covered service performed, you will be responsible for the visit.

Patient Signature ______________________________ Date ______________________

Medicare Patients: The signature on file indicates I request payment of authorized Medicare benefits be made either to me or on my behalf to Augusta Women's Health & Wellness Center for service furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to health care financing administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claim, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's name (please print) ____________________________________
PROVIDER: Dr. Donna Adams- Pickett, Augusta Women's Health & Wellness Center
Patient's Signature ____
Patient's Medicare no: ____________________ Date: ____________________

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ASSIGNMENT OF INSURANCE BENEFITS: (Patients with Insurances please read/sign below)

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Augusta Women's Health & Wellness Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment may be considered valid as an original. I understand I am financially responsible for al] charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment,

Signature: ______________ Date_________________

ASSIGNMENT OF BENEFITS/ AUTHORIZATION FOR TREATMENTS:

I have read, understood, and agree to the above financial policy for payment of professional fees. I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or to myself. I understand that I am financially responsible for all charges not covered by my insurance.

Signature: _______________Date__________________