The Madison Midwives
Pregnancy, Birth, and Beyond

Physicians for Women
Obstetrics & Gynecology

Phases
Primary Health Care for women

(608) 441-1730 (608) 227-7007 (608) 441-1455

FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your health care provider. We are committed to your successful treatment. We require all patients to read and sign our Financial Policy prior to receiving any services.

It is the policy of this clinic(s) that **all outstanding balances are to be paid in full** upon receipt of a current statement. Any patients that no show for an appointment without contacting the clinic will be charged a **No Show Fee of $25.00**. Patients will be charged a fee of **$30.00 for any checks returned for non-sufficient funds**. We accept cash, checks and Visa, MasterCard, or Discover.

Insurance:

As a courtesy, we submit your claim for services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company; we are not a party to that contract. Be aware that some of our services may not be covered by your insurance policy**.**

By presenting for care, you agree you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed. You are responsible to understand your insurance coverage and for any balance.

Minor Patients:

The adults accompanying or the parents/ guardians of a minor are responsible for payment of co-pays.

Acknowledgement and Acceptance:

I have read and fully understand the above. I authorize the release of information for the purpose of payment and insurance benefits and authorize payment directly to Melius, Schurr & Cardwell for services rendered to me and/or my dependents.

I further accept responsibility for the payment of co-payments, deductibles and coinsurance, as well as any services **that are not covered or paid by my insurance plan**. **Balances due on my account shall be paid in full upon receipt of a current statement.**

_____ _____

(Patient/Authorized Representative Signature) (Date)

MEDICARE PATIENTS ONLY

I authorize the release of any medical information necessary to process claims. I request payment of my Medicare benefits to Melius, Schurr, and Cardwell, LLP or Phases, Primary Healthcare for Women for services rendered.

_____ _____

(Patient/Authorized Representative Signature) (Date)