FINANCIAL POLICY

Thank you for choosing Seattle Women's & Moms' Clinic (SWMC) for your care. We are honored to be of service to you. The following is a statement of our financial policy. We want you to understand it and be comfortable with it. We require that you read it and sign it prior to receiving evaluation or treatment from us. Please do not hesitate to ask questions or discuss any concerns.

- **Forms of Payment:** We accept Check, HSA card, Visa, Mastercard, Discover, and American Express.
- **Credit Card on File:** We require that you keep a card on file with SWMC (see our Credit Card on File policy).

- **Patients with Insurance:** We are contracted with insurance plans, and can submit claims to most carriers, both primary and secondary plans. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage, benefits and limitations. We bill your insurance carrier as a courtesy; ultimately you are responsible for the full charges of your visit. **It is your responsibility to understand and comply with any pre-determination of benefits or referral requirements.** It is also your responsibility to know your deductible and out of pocket financial obligation. If your insurance carrier declines a claim due to inaccurate or incomplete information you have provided to us or to them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance carrier before seeking payment from you. As a courtesy, we will help you as best we can to get proper and timely payment from your insurance carrier.
- **In Network Coverage:** Your co-pay is due at the time of each visit. Once your insurance carrier processes your claim, we will bill you for the remaining balance as per our Credit Card on File policy.
- **Out of Network Coverage:** If we do not have a contract with your insurance carrier, depending on carrier, we may attempt to bill your insurance carrier for the balance, BUT FOR SOME CARRIERS WE ARE UNABLE TO AND PATIENT IS RESPONSIBLE for submitting the bill for reimbursement from their carrier, and is responsible at time of service to compensate SWMC for services rendered. Your insurance carrier will reimburse at an out-of-network provider rate. This may mean a higher deductible or co pay. It is your responsibility to make sure you have out-of-network benefits. Your remaining balance may be higher than a balance for the same services provided by an in-network provider. Your copayment is due at the time of your visit. Once your insurance carrier processes your claim, we will bill you for the remaining balance as per our Credit Card on File policy.
- **Non-covered Services:** Some services cannot be submitted to insurance. Some insurance carriers deem certain procedures as cosmetic, such as skin tag removals. It is your responsibility to understand your benefits.
- **Private/Self-Pay Patient:** you are responsible for paying for treatment at time of service. You may pay for services via credit/debit card.
- **Missed Appointments/Cancellations:** If you no-show or cancel/reschedule an appointment without 48 hours' notice, there will be a $100 fee.
- **Returned Check Policy:** If any payment is returned due to insufficient funds, there will be a $50 fee added to the balance due.
- **Billing Service:** Your credit card on file will be used to pay any patient balance due, once your insurance has processed the claim (see our Credit Card on File policy). Please do not hesitate to contact our clinic with any questions or concerns about your statement, or if you wish to pay your balance by phone. Your signature below authorizes payment of medical benefits to Seattle Women's & Moms' Clinic (SWMC) for any services furnished by providers of Seattle Women's & Moms' Clinic (SWMC). You authorize the provider, Lise Martin, ARNP and clinic to release any information necessary to process insurance claims. This authorization is in effect indefinitely until revoked in writing.

My signature below indicates that I have read, understand, and agree to this Financial Policy.

Name of Patient (or Responsible Party):_____

Signature of Patient (or Responsible Party): _____

Date (month/day/year):_____

Last revision Jan2020