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PROGRESSIVE CARE FOR WOMEN'S PAYMENT POLICY

I hereby acknowledge the following payment policy of Progressive Care for Women (PC4W):

1. Payment of copays, patient portions and balances due are expected at the time that services are rendered.
2. PC4W will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay PC4W for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier delays or withholds payment of its portion for more than 90 days from the date of service, both the insurance and patient portions of your account then become your responsibility. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.
3. **After your insurance carrier pays its portion of the claim, you may be responsible for a patient portion. Our office does not send out billing statements. Your insurance company will send you your explanation of benefits (EOB), reflecting what you owe the office. Your credit card will automatically be processed for your remaining patient portion two weeks from the date your claim was processed. A receipt will be then be emailed.**

We strongly suggest that you monitor your account and the explanation of benefit forms that you receive from your insurer. You should resolve all disputes involving patient portions and explanations of benefits with your insurance carrier.

CREDIT CARD AUTHORIZATION

I hereby authorize PC4W to charge my credit card for outstanding balances and patient portions owed PC4W, as provided in this Payment Policy.

Name of Patient: ______________________________ D.O.B: ___ ___/___ ___/___ ___
Last First MI

Type of Card: Visa Mastercard AMEX Discover

Is this a Health Savings Account (HSA) or Flex Spending Account (FSA)? YES No

Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Exp Date: ________/________ Security Code: ____________

Billing Address: ______________________________
Street Apt Number

____
City State Zip Code

Name of Cardholder: ______________________________
Last First MI

Authorized Signature: ______________________________ Date: ____________

Revised 02/2018