FINANCIAL STATEMENTS POLICY

SUBMIT

The New Hope Center is committed to providing quality health care. We want to ensure that our patients' health not be compromised or neglected by a harsh or inflexible credit policy. We strive to have a uniform, fair, and consistent procedure for handling of all patient accounts, which encourages the prompt payment of all medical debts through reasonable and effective procedures and follow-up. As such, we will deal with you fairly, equitable, and with sensitivity in all financial matters. We believe that a clear understanding of our fees and financial policies is important for The New Hope Center and you. _____ (Initials)

Verification of Insurance Benefits

By providing our office with your insurance plan information, our staff is able to contact your carrier and verify your specific insurance benefits. The information we obtain from your insurance carrier is the amount of your co-pay, the amount of your yearly deductible, your GYN benefits, your infertility benefits (if any exist), and whether or not your plan requires a referral, and/or if a prior authorization is necessary for your initial visit and/or any other procedures that might be employed during your treatment at The New Hope Center. A "verification of benefits" is NOT a guarantee of payment by your insurance carrier. Your insurance company may require a referral, pre-certification/pre-authorization, or certain medical criteria be met before coverage and payment is made for intended services. Base upon quoted coverage, our staff will contact your carrier before performing procedures, to ascertain whether or not prior notification is required. The New Hope Center is in no way guaranteeing that your insurance carrier will make payment as they have indicated, nor is The New Hope Center, or its staff, responsible for any inaccurate information your carrier may quote. If your insurance requires a co-payment, cost share, or deductible, you will be required to pay this at the time of your visit. _____ *(Initials)*

Insurance Referrals

Your insurance carrier may require a Primary Care Physician (PCP) referral to authorize your services at our Center. Obtaining a referral is your responsibility as required by your carrier. If a referral is not obtained, you will be fully responsible for all charges incurred and related to any visit for which a referral was not provided to our office prior to your visit. _____*(Initials)*

MD Letter for Pre-Authorization, Appeals, and/or Disability or Life Insurance Forms

There is a charge of $50.00 for each letter or form requested. Insurance carriers do not cover this cost and is deemed patient responsibility & due prior to completion of forms. However if you are having any In Patient surgical procedures, this charge will be waived. _____ *(Initials)*

Insurance Claims

Insurance claims will be filed when: The New Hope Center participates with the patient's insurance carrier, and the services are covered under the patient's policy/plan, and the services are pre-approved/authorized by the patient's carrier, and we have received accurate demographic and insurance information. We will file with as many as two insurance companies on behalf of the patient. If your insurance company has not responded within 60 days of submitting the claim, or responds with a denial for payment, you will be responsible for payment of your balance and for follow-up with your insurance carrier for reimbursement. _____ *(Initials)*

Non-Participating Insurance or Uninsured Patients

The New Hope Center does not deny care to patients whose insurance carrier we are non-participating, or who find themselves without insurance. These patients are classified as "Cash", and are required to sign a "Cash Payment Agreement" at their

first office visit. "Cash" Patients are required to pay the fees associated with their care at the time services are rendered. "Cash" patients may be eligible for one of The New Hope Center's discount programs if payment for services rendered is received before the actual service is provided. If your insurance requires a co-payment, cost share, or deductible, you will be required to pay this at the time of your visit. _____ *(Initials)*

Non-Covered Services/Procedures:

While many of the services provided by The New Hope Center may be covered under your individual insurance plan, there are several, that may not. Individual insurance policies differ for each patient, employer, plan, and carrier, but most policies and carriers, do not cover In-Vitro Fertilization (IVF), artificial insemination (IUI), or other Assisted Reproductive Technology (ART) services. In addition, the office visits, laboratory services, and/or ultrasounds performed in relation to these procedures, may not be covered as well. Payment for the charges of any/all procedures or services that are non-covered under the patient's insurance plan, are the patient's responsibility, for which payment is due in full at the time of service. If you have specific questions regarding your plan benefits, please refer to your "member handbook", or contact a representative in your H.R. Department. If your insurance requires a co-payment, cost share, or deductible, you will be required to pay this at the time of your visit. _____ *(Initials)*

Monthly Statements

All patients will receive a monthly statement informing them of the patient balance and the balance pending with their insurance company (if insured, a participating carrier, and if services are covered under the policy). Those patient who are "Cash", will receive a monthly statement informing them of the patient balance only. Any balance shown as "patient due" is due upon receipt, and payment to be made to The New Hope Center. _____ *(Initials)*

Collections

Account balances are due upon receipt of your billing statement. Any balances left unpaid after 30 days of the billing statement date, are considered "past due", and must be paid immediately, in order to remain in good standing. If payment has not been received within 90 days, we will begin the necessary steps to send the account to our collection agency. A payment plan can be set up through our accounts department, to avoid these proceedings. _____*(Initials)*

Electronic Notification

I wish to be contacted by e-mail/electronic communication at: _____by the Physician/s and other personnel on staff at The New Hope Center for Reproductive Medicine, for or with the following types of information:

(Click all that apply) ☐ **Appointments** ☐ **Billing & Account Information** ☐ **Clinical Information**

I understand that I can revoke this request and/or provide changes at any time. We also understand that due to certain unforeseen circumstances, it may be necessary for you to cancel or reschedule an appointment. Our office requires a minimum of 24-hour notice of any time or date change. Failure to contact our office may result in a $25.00 missed appointment charge. _____*(Initials)*

Acknowledgement of Privacy Notice:

I acknowledge and agree that I have been provided with a copy of Mid-Atlantic Women's Care Privacy Notice pursuant to the Federal regulations known as the HIPAA Privacy Rule. _____*(Initials)*

Assignment of Benefits/Obligation of Payment

I hereby assign, transfer, and set over to The New Hope Center for Reproductive Medicine-A Division of MAWC, PLC, all of my rights, title, and interest to my medical reimbursements under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization I understand that I am financial responsible for all charges whether or not they are covered by insurance. If payment for services are rendered when due, I agree to pay finance charges of not less than $0.50 and not more than 1.5% of my balance if payment has not been received within 30 days. I further agree to be financially responsible for all collection costs incurred in the reconciliation of my debt, including but not limited to 33 1/3% for attorney's fees, collection agency fees and all court costs. _____*(Initials)*

HIV Disclosure

A law was enacted in the state of Virginia in 1989 which authorized healthcare providers to test their patients for HIV antibodies when the healthcare provider is exposed to body fluids of a patient in a matter which may transmit human immunodeficiency virus (HIV-Aids Virus). In the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the healthcare provider who may have been exposed. You will be offered the opportunity for a face-to-face disclosure of the results of the HIV test and counseling. _____ *(Initials)*

Patient Acknowledgement:

I acknowledge that I have read, understand, and agree with the terms of The New Hope Center's policy notifications.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Witnessed by NHC Representative: _____ Date: _____