Woman to Woman
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FINANCIAL POLICIES

Thank you for choosing our practice for your obstetrics and gynecological needs. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship.

Please ask if you have any question about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

CO-PAYS

The patient or responsible party is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. We accept cash, checks, pay-pal, or credit cards.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. We suggest you contact your insurance company in regards to whether we are preferred contracted providers. We will bill your primary, secondary, and tertiary insurance companies as a courtesy to you. To properly bill your insurance companies, we require that you disclose all insurance information.

Failure to provide complete insurance information may result in patient responsibility for the entire bill. If you fail to provide us with insurance coverage for services in a timely manner and your insurance company denies for timely filing, you agree to take full responsibility for those charges. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits once they receive the insurance claim.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. To reiterate it is your responsibility as the covered insured on your insurance to know your benefits and exclusions of your policy. We will not fraudulently change diagnoses from the supporting documentation for a better outcome from your insurance company. If we have exhausted all our efforts in collecting from your insurance and payment is delayed over 90 days, you agree to take responsibility of those charges in arrears up with your insurance company and pay our office in full for such charges.

We do supply some services that we are aware of that insurance carriers do not consider a covered benefit of contracts such as infertility testing, ultrasounds done to determine sex of baby, and with some policies IUD devices. For any noncovered services we will require payment in full on the day of services. If you are scheduled for a surgical procedure or IUD ordered by our office, we will expect your copayment, coinsurance, and/or deductible prior to the services provided.

REFERRALS AND PRE-AUTHORIZATIONS

If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, and/or patients without an insurance card on file with us. If there is a discrepancy with the information you have provided to us, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full at time of service.

MISSED APPOINTMENTS

There will be a $25 fee for missed appointments if you do not give a 24-hour notice. This charge cannot be billed to your insurance; therefore, it will be solely your responsibility. After three consecutive missed appointments, you may be dismissed from our practices.

RETURNED CHECKS

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Payment on non-sufficient funds checks are expected immediately upon notice from financial institution.

MEDICAL RECORD COPIES

All requests for medical records must be done so in writing please allow us 10 working days to complete your request this is within the legal limits. Please be advised that there is an administrative fee of $15 and a fee of $0.50 per page this is assessed at the discretion of our office and is in accordance with Montana Annotated code.

PRESCRIPTION REFILL REQUESTS

It is our office policy to refill medications during office hours only. We are required to keep accurate records of all medications prescribed to stay within state and federal laws and prescribing guidelines. Therefore, when you notice you have only three days remaining, please call your pharmacy. If you need another refill the pharmacist will contact us via phone or faxed request. Faxed requests are the preferred method for refill requests and create less chance of errors of the wrong drug or dosage being refilled. Allow 72 hours (3 working days) for our office to refill your prescription(s) in a timely manner.

MINORS

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. Minors must be accompanied by a parent or guardian unless a signed release to treat and financial arrangements have been made prior to services.

OUTSTANDING BALANCE POLICY

It is our office policy that all accounts are paid within 90 days. All past due accounts will be sent a 60-day collection letters. If payment is not received within the 90 days, the account will be sent to the collection agency that we work with, I understand that I am personally responsible to pay all collections fees associated with my account, including a reasonable attorney fees and reasonable agency fees. I understand that in the event my account is turned over to a third-party collection agency, a collection fee is the amount of up to 50% of my account balance will be added to my balance and that I am responsible to pay that amount. Once your account is turned over to the collection agency you will be considered discharged from the practice until financial obligations have been met and satisfied. If financial obligations are met you will be welcomed back into our practice but as a cash at time of service patient until a sufficient period of time.

REFUNDS

If a refund is due to you and payment was made via credit card (master card or visa), please be advised that a 2% to 5% fee will be deducted from your refund due to credit card fees. Patient using a care credit card, please be advised that a 15% fee will be deducted from your refund due to care credit fees.

CELL PHONES

By providing a cell phone number you have authorized contact for any activity involving our services to you, including but not limited to the resolution to the balance of your account. This number will only be used for in-house or any business entity contracted to perform duties resulting from services provided to you by this office.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving services, you are ultimately responsible for payments on your balance. Our office will not bill any other personal party.

Authorization to Release Information and Assignment of Medical Benefits:

I hereby authorize Valerie A. Knudsen, MD to treat the above-named patient. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies of this are valid as the original. I authorize medical benefits to be directly paid to Valerie A. Knudsen, MD. I understand that I am financially responsible for any services from this office regardless of insurance coverage.

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Printed (patient) Patient DOB

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Signed (patient) Date

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Printed (authorized guarantor) Signed (authorized guarantor)