Carolina Elite Women's Care, PA

934 Vandora Springs Road
Garner, NC 27529

919.977.9075 phone
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Our Office Policies and Procedures

Chart#: ____________________ Patient's Name: ____

We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. These policies and procedures will establish the expectations you will receive from Carolina Elite Women's Care and also what we expect from you as our patient.

1. APPOINTMENTS: We ask that all patients arrive at least 20-30 minutes prior to your actual appointment time. Late arrivals may be asked to reschedule your appointment. Failure to submit completed demographic information, appropriate health history or this signed form may result in the rescheduling of your appointment.
2. MISSED APPOINTMENT: You (not your insurance company) will be charged for a missed appointment unless cancelled 24 hours in advance.
3. INSURANCE: ***Proof of current insurance coverage must be presented at each visit, if not you will be responsible for payment in full at the time of your visit to our office.*** If applicable, after presenting valid insurance information, you may receive a refund (within 30 days) upon payment of services by your insurance company. If Carolina Elite Women's Care is not contracted with your insurance carrier, you are responsible for payment in full at the time of your visit. If your insurance company deems your visit a non-covered service, you will be responsible for payment in full. Contact your insurance company prior to all visits to confirm coverage.
4. PREVENTIVE PHYSICAL/ANNUAL VISITS: Please be aware that most insurance companies cover one (1) preventive, annual physical per plan year. ***Additional concerns or problems addressed at this particular visit will qualify as an additional problem visit and your insurance company may require additional co-pays, deductible or co-insurance*** to address these additional concerns or problems at this visit. It is the patient's responsibility to verify insurance benefits and financial responsibility before all appointments.
5. CO-PAYS, DEDUCTIBLES, AND FEES: Co-pays, insurance deductibles and fees for services not covered by your insurance policy, are typically collected at the time a service is rendered. You may also choose to keep your Credit Card on File to cover any outstanding balances or future balances.
6. COMPLETION OF FORMS/LETTERS: A fee will be charged as patient responsibility for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability forms, FMLA forms, Leave of Absence forms, Mail Order Medication forms, Letters regarding flying and or airline tickets, coverage of Birth Control Pills, and letters to employers.
7. AFTER HOURS QUESTIONS, PROBLEMS OR PRESCRIPTION REFILLS: For non-emergent questions, problems or prescriptions we ask that you please call during regular office hours; otherwise a fee may be billed to you for these non-urgent services after office hours.
8. LABORATORIES: It is the patient's responsibility to notify our office, at each visit, if your insurance requires you to use a laboratory that is NOT used by our office. The laboratories used by our office are posted in each exam room and listed here. Questions regarding laboratory bills should be directed to that laboratory. Primary lab used at this time: UNC/Rex Healthcare Laboratory.
9. PAST DUE ACCOUNTS: Payment is due when services are rendered. If we file your insurance and they pay their portion, any remaining balance is your responsibility. You will receive 3 monthly bills from our office. If you have not paid in full or arranged and honored a payment plan within 3 months, your account will be considered for transfer to an outside collection agency and termination of our patient relationship. Please contact our office to discuss any past due accounts.

This is an agreement between you, the patient, and Carolina Elite Women's Care. By signing this agreement, you agree to abide by all the policies and procedures stated within.

Signature of Patient/Responsible Party: ________________________________ Date: ______/______/______