Carolina Elite
WOMEN'S CARE
OBSTETRICS | GYNECOLOGY

OFFICE POLICIES & PROCEDURES / AGREEMENT

Patient's Name:_____ **Chart #_____**

We are pleased to participate in your health care and look forward to establishing a lasting relationship as your healthcare provider. These policies and procedures will establish the expectations you will receive from **Carolina Elite Women's Care (CEWC)** 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 will be charged $50.00 for a missed appointment unless canceled at least 24 hours before your appointment. If you miss 3 appointments without at least 24 hours notice within 1 year our staff will only reserve same day appointments based on provider availability. Same day appointments may not be guaranteed. Multiple same-day cancellations or no-show appointments could also result in termination from the practice. There is a $250.00 charge for rescheduling or cancelling surgeries with less than one weeks notice_____ **(INITIAL)**.

3. **CREDIT CARD ON FILE:** We can keep your credit or debit card on file as a convenient method of payment for services not covered by your insurance, but for which you are liable. Additionally, we use this method of payment for missed appointments and cancellations with less than 24 hours notice. Your credit card information is kept confidential and secure. Please initial beside the following that applies to you. **Please select 1 of the following:**

   I AUTHORIZE CEWC to charge the portion of my bill that is my financial responsibility and to charge my credit card for missed appointments or cancellations with less than 24 hours notice. _____ (INITIAL)

   OR

   I DO NOT AUTHORIZE CEWC to keep a credit card on file. Instead, I am responsible for all payments prior to the time of service. _____ (INITIAL)

4. **INSURANCE:** ***Proof of current insurance coverage must be presented at each visit. If not, you are responsible for payment in full at the time of your visit.*** If applicable, after presenting valid insurance information, you may receive a refund (within 30 days) upon payment of services by your insurance company. If CEWC 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. If you have more than one active insurance plan, it is your responsibility to inform our office. Contact your insurance company prior to all visits to confirm coverage and network status.

5. **PREVENTIVE PHYSICAL/ANNUAL VISITS**: Most insurance companies cover 1 preventative, annual physical per plan year and, depending on age, one pap smear every three to five years. Additional concerns or problems addressed at this particular visit 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.

6. **CO-PAYS, DEDUCTIBLES, AND FEES**: Co-pays, insurance deductibles and fees for services not covered by your insurance policy are collected at the time service is rendered.

7. **COMPLETION OF FORMS/LETTERS:** There is a $25 fee for completion of forms which must be paid prior to the release of the form, including the following, but not limited to: Disability Forms, FMLA, Leave of Absence, Mail Order Medication forms, Letters regarding flying and/or airline tickets, coverage of Birth Control pills, and letters to employers. _____ **(INITIAL)**

8. **AFTER HOURS QUESTIONS, PROBLEMS OR PRESCRIPTION REFILLS:** For non-emergent questions, problems, or prescriptions please call during regular office hours. A fee may be billed to you for non-urgent services after office hours.

9. **LABORATORIES:** Lab services are provided primarily by Labcorp and NxGen as a patient courtesy, and are billed directly from these third party entities, not CEWC. 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. Questions regarding laboratory bills should be directed to that laboratory.

10. **PAST DUE ACCOUNTS:** Payment is due when services are rendered. If we file your insurance and they pay their portion, any remaining balance is the patient's 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 will proceed. You will also incur a $10 fee if an outstanding balance goes to collections.

11. **INSUFFICIENT FUNDS:** If a check payment has insufficient funds, a $35 fee will be added to the current balance. Please contact our office to discuss any past due accounts.

12. I have received a copy of the Notice of Privacy Practices (HIPAA Policy)

This is an agreement between you, the patient, and **CEWC.** By signing this agreement, you agree to abide by all the policies and procedures stated within.

Signature of Patient/Responsible Party: _____

Date: _____/_____/__2024____