WomanCare, P.C.
Payment Policy and Authorization

I understand that all charges incurred are the personal/responsibility of the patient/guarantor. I authorize payment for services rendered to be paid directly to WomanCare, P.C. and if correct information is supplied at the time of visit, that managed care insurance is filed with the contracted carriers. The patient/ guarantor is responsible for all residual balances including but not limited to copays, deductibles, coinsurance and charges not paid by insurance carrier for any reason, after consideration of contractual adjustments.

Obstetrical patients, with commercial insurance, are required to pay 20% of their expected delivery fee by 20 weeks gestation. Patients without insurance are required to sign and guarantee a contract for OB care with their credit card, and to make the required payments as outlined in the contract. Non-guaranteed contracts are payable in-full at contract signing time. Other services, not covered as part of global obstetrical care are due payable at the time services are rendered.

Surgical patients are required to pay their deductible and coinsurance amounts PRIOR to their scheduled surgery date, unless otherwise stipulated by contract with a managed care insurer.

In addition to the principle amount owed, I agree to pay 33.33% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account.

I understand that I am entering into a contractual relationship with WomanCare, P.C. and its physicians for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by WomanCare and its physicians, I, the patient/guardian, agree not or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against WomanCare, P.C. and its physicians.

Should I initiate or pursue a meritorious medical malpractice claim against WomanCare, P.C. and its physicians, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists in the same specialty as WomanCare, P.C. and its physicians. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American College of Obstetrics and Gynecology. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American College of Obstetrics and Gynecology. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration, WomanCare, P.C. and its physicians also agrees to exactly the same above referenced stipulations. Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim. Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents. Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery. Patient/guardian acknowledges that she has been given ample opportunity to read this agreement and to ask questions about it.

I acknowledge that I have fully read and understand all the terms and conditions, as well as any charges and payment terms associated with this contract, and hereby agree to be bound by all of the above terms.

AUTHORIZATION TO RELEASE INFORMATION

I authorize WomanCare, P.C. to release any information needed, including the diagnosis and record of any treatment/examination rendered to me or my dependents to secure payment of benefits.

Patient/Guardian Signature _____ Print Name_____ Date_____

Physician Signature _____ Print Name_____ Date_____