5319 Parkshire Way • North Charleston, S.C 29418 • (843) 767-2121 • Fax: (843) 767-2102

Financial Agreement

Payment is to be paid in full at time of service. Your financial portion will be collected upfront. We will not guarantee retro-active coverage and will collect payment in full at time of service. You may be charged a billing fee of $10.00 if deductible or co-pay is not paid at the time of service.

The providers are here to provide you the best possible medical care; therefore, they will not field any questions concerning financial obligations. Any such questions should be directed to our insurance billing specialist, Irving Industries at (843) 851-1355 and/or the office manager of Charleston Women's Wellness Center.

Insurance is filed as a courtesy and not an obligation. Any remaining balances after insurance has reported, are to be paid within thirty (30) days of notification to the patient. All balances are the sole responsibility of the patient, or the parent/guardian of the minor patient. It is the responsibility of the patient and the insurer to be knowledgeable of your own insurance policy. Including covered services, deductible information, co-pays and pre-existing clauses. Any problems of non-payment from the insurance companies will become the immediate responsibility of the patient and all accounts must be settled with thirty (30) days of notification, unless payment arrangements have been made between the patient and our insurance billing specialist, Irving Industries. We will provide information and documentation to the patient to help them negotiate with their insurance carrier.

Patients with no insurance or proof of insurance on the date of service will be considered self-pay. Self-pay patients will sign this form indicating that they have **NO** health insurance and will be responsible for the total balance on the date of service. However, this discount does not apply to medications, shots or labs. It applies only to office visits and procedures.

***Co-pays, balances due and patients' financial portions for services provided will be collected upon check-in on date of service.**

In all cases, insured or self-pay, collections notices will begin if the patient owed balance is not received within 90 days of notification to the patient. All unpaid balances will be sent to an outside agency after all efforts have been exhausted. this may result in your dismissal from the practice. The patient will be responsible for all collection cost to include court fees and attorney fees should the practice have to pursue delinquent accounts in small claims court.

By signing below, you accept the terms stated above and allow us to file your insurance and accept assignment of your insurance benefits. In the event that your insurance company requests copies of your records for benefit determination, you authorize us to provide any and all information to them necessary for maximum benefits.

I ____ (have/do not have) heath insurance coverage, have read, understand and agree to accept the terms and conditions stated above.

______________________________ Patient Signature

____________________ Date

______________________________ Responsible Party Signature
(If not patient being seen)

____________________ Relationship to patient

______________________________ (Account #)

____________________ Staff Initials