Louisville Women's HealthCare

601 South Floyd St.
Suite 300
Louisville, KY 40202
Appointments: 502-271-5999
Laboratory: 502-271-5995
Fax: 502-271-5994

Patient Payment Policy

Thank you for choosing our medical practice. We are committed to provide the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. Please sign below that you have read and agree to this policy.

Contracted Insurance Policy - If an insurance company with whom we have a contractual agreement insures you, you will be responsible for your co-payment and/or any deductible or non-covered services at the time the service is rendered.
Non-Contracted Insurance Policy - If any insurance company with whom we do not have a contractual agreement insures you, you will be responsible for payment in full at the time service is rendered.
Minors of Divorced Parent - The parent(s)/guardian accompanying the patient is/are responsible for payment at the time service is rendered.

Payment Policy
Payment for service is due in full at the time of service.

- We accept cash, check, Visa, MasterCard and Discover -
- All fees are based on the type of service provided for your care and related services.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.
- For elective or uncovered surgical services, all co-payments and deductibles are due prior to your surgery.
- If your account is more than 60 days overdue, it will be referred to an outside collection agency. This is a last resort and done reluctantly, after we have exhausted efforts for voluntary payment. Collection and Court cost will be added to the patient's account should this become necessary.

Referrals
It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit could be *rescheduled,* or you may be financially responsible.

Other providers, i.e. Anesthesiologists, radiologists, pathologists, and hospitals who may provide care to you during the time you are I under the care of one of the OB/GYN Associates Provider, it is the PATIENT'S responsibility to ensure that these other providers are I participating providers with your insurance carrier.

Acknowledgement and Authorization

I have read, understand, and agree to the above patient policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility to pay at the time services are rendered.

I authorize my insurance benefits to be paid directly to University OB/GYN Associates, PSC.

I authorize University OB/GYN Associates, PSC to release any medical or other information to my insurance company when requested.

____ ____________________
Signature Date

It is your responsibility to let us know of any insurance changes. If we do not have your current insurance information, then payment is expected at the time service is rendered.