Progressive Care For Women's Payment Policy

I hereby acknowledge the following payment policy of Progressive Care for Women (PC4W):

1. Payment of copays, patient portions and balances due are expected at the time that services are rendered.

2. PC4W will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay PC4W for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier delays or withholds payment of its portion for more than **90 days** from the date of service, both the insurance and patient portions of your account then become your responsibility. Our office policy is to automatically charge your credit card for any outstanding balance after your account becomes more than 90 days past due. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment. We will also contact you and give you the option of receiving a refund.

3. After your insurance carrier pays its portion of the claim, you may be responsible for a patient portion, due to such factors as uncovered services, copayments or unmet deductibles, as outlined in your particular insurance plan. We will send you a billing statement outlining this patient portion. You will have **30 days** from the date of the billing statement to submit payment for these charges, after which time we will automatically charge your credit card for the entire amount of the patient portion.

We strongly suggest that you monitor your account and the explanation of benefit forms that you receive from your insurer. You should resolve all disputes involving patient portions and explanation of benefits directly with your insurance carrier.

Credit Card Authorization

I hereby authorize PC4W to charge my credit card for outstanding balances and patient portions owed PC4W, as provided in this Payment Policy.

Name of Cardholder: _____ _____ _____
Last First MI

Name of Patient: _____ _____ _____
Last First MI

Type of Card: ___Visa ___Mastercard ___AMEX ___Discover

Card Number: _____

Exp Date: ____/_____ Security Code: _____

Billing Address: _____

_____ _____ _____
City State Zip Code

Authorized Signature: _____