



Financial Responsibility Agreement

Please initial each line after reading.

I accept full financial responsibility for medical expenses incurred at Women's Health Associates, P.C.;

- for services provided that are not covered by my insurance plan; _____
- for services provided if I do not obtain a referral that may be required by my insurance plan; _____
- for services provided if I do not designate a Primary Care Physician (PCP) with my insurance plan and one is required; _____
- for services that are not paid by my insurance plan with the 45 days required by law. I understand that WHA will then forward the balance to me until remittance is received from my insurance company, upon which time I will receive a refund; _____
- I understand that, I will be charged a \$50.00 fee if I do not show up for a scheduled appointment or cancel an appointment on the same day that it is scheduled. _____

I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold Women's Health Associates, P.C. responsible for verifying this information. I accept financial responsibility for any lapse on my part in providing and/or understanding my insurance benefits information at the time services are rendered.

Signature

Witness Signature

Printed Name

Printed Name

Primary Insurance Plan

Date

Date