STAFF USE ONLY

Calculated personal income:________________month / year
Calculated partner income:________________month / year
Additional income: ________________month / year
TOTAL INCOME: ________________month / year

Quarter: 1 2 3 4 Verified by: _________
Verification? Yes No
Type of verification/reason: ________________
Code: 1 2 3 4 5 Insured

INSURANCE AND PAYMENT POLICIES

PAYMENT FOR SERVICES:

Payment is due at time-of-service, including co-pays and deductibles payments. We accept cash, credit cards, checks (for some services), and money orders. Returned check fee is $20. Please note that all quotes are estimates; final appointment cost may changewith changes in income information or services received. Statements will be sent to your address for all unpaid balances, so please discuss confidentiality concerns with staff before your visit.

CONFIDENTIALITY, COVERAGE AND PAYMENT WITH INSURANCE

Confidentiality is not guaranteed for services charged to your insurance company, especially if you are not the policy holder.
The insurance company may send a summary of charges to the address they have on-file. If you want these statements to go to adifferent address, you must contact your insurance company directly. Our staff do not know which services are covered by your insurance. It is your responsibility to verify covered services for your specific plan/policy. This includes requirements, limitations, andpolicies regarding referrals, prior authorizations, co-payments, co-insurance, deductibles, and benefits. Please direct questions about coverage to your insurance plan administrator. If the insurance carrier denies your claim, you are responsible for any outstanding balancethat remains unpaid by your insurance.

CHOOSE ONE:

I HAVE HEALTH INSURANCE THAT CAN BE USED AT WOMEN'S HEALTH.

☐ I REQUEST THAT YOU BILL MY INSURANCE DIRECTLY.

Present insurance card to front desk. I request and assign all payments of authorized benefits be made on my behalf to BoulderValley Women's Health Center for any services that I receive. I authorize BVWHC to file appeals on my behalf for any denial of payment. I understand that there are services my insurance plan may not cover. I understand that my provider may recommendadditional services or tests and that they may result in additional charges.

Primary Insurance Company Name: ______________________________
Whose policy is it? Mine Parent/Guardian Spouse/Partner Other ______________
Policy Holder's Name, if other than patient: __________________________ Date of Birth: ____________
Address:__________________________________City:________________State:_____Zip: ________

Secondary Insurance Company Name: ______________________________
Whose policy is it? Mine Parent/Guardian Spouse/Partner Other ______________
Policy Holder's Name, if other than patient: __________________________ Date of Birth: ____________
Address:__________________________________City:________________State:_____Zip: ________

☐ I DO NOT WANT TO USE MY INSURANCE. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.

I DO NOT HAVE INSURANCE

☐ I WOULD LIKE TO KNOW IF I AM ELIGIBLE FOR INSURANCE OR A DISCOUNT.

Proof-of-income is required for enrollment and discounts.

☐ I DO NOT WANT TO DECLARE MY INCOME. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.

I QUALIFY FOR TEEN CLINIC SLIDING SCALE

☐ I AM LESS THAN 20 YEARS OLD AND I DON'T WANT MY PARENT(S)/GUARDIAN TO KNOW I RECEIVE SERVICES HERE **OR** I DON'T HAVE INSURANCE.

Teen discounts are not available for abortion care, dating ultrasounds, vaccines, or Mirena (IUD).

PRE-TAX INCOME INFORMATION

Even if you have insurance, please provide income information. You may be eligible for discounts if your insurance does not cover all charges.

ARE YOU EMPLOYED? No Yes - Occupation: __________________________
HOW MANY PEOPLE, INCLUDING YOU, DOES THE REPORTED INCOME SUPPORT? ________
PERSONAL IMCOME: Hourly rate $________ Average hours worked per week__________ OR Annual salary $__________
PARTNER'S INCOME: Hourly rate $________ Average hours worked per week__________ OR Annual salary $__________
ADDITIONAL INCOME:

Unemployment benefits	$_______/month
Parental or Family Support (for rent, bills etc.)	$_______/month
Savings/Inheritance (trust fund, etc.)	$_______/month
Child Support/Alimony	$_______/month
Disability or Social Security	$_______/month
Other ____________________	$_______/month

ALL PATIENTS

I have read and agree to this financial policy. The information I provided is accurate to the best of my knowledge.

NAME: ______________________ SIGNATURE: ______________________ DATE: ________________