2019 INSURANCE AND PAYMENT POLICIES

WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

CHOOSE ONE:

☐ **1** **I HAVE HEALTH INSURANCE THAT CAN BE USED AT WOMEN'S HEALTH. I REQUEST THAT YOU BILLMY INSURANCE DIRECTLY.**
Present insurance card to front desk. Co-pays and deductible/co-insurance prepayments may be required. It is your responsibility to verify with your insurance company that we are an in-network provider for your specific plan.

☐ **2** **I HAVE HEALTH INSURANCE BUT I CHOOSE NOT TO USE IT. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.**
Payment is due at time-of-service. Let us know if insurance is a confidentiality issue for you.

☐ **3** **I DO NOT HAVE INSURANCE AND I WOULD LIKE TO KNOW IF I AM ELIGIBLE FOR INSURANCE OR A DISCOUNT.**
If eligible for insurance, please meet with our enrollment specialist before receiving services. Proof-of-income is required for enrollment and discounts.

☐ **4** **I DO NOT HAVE INSURANCE AND I DO NOT WANT TO DECLARE MY INCOME. I AGREE TO PAY THE FULL RATE FOR ALL SERVICES.**
Payment is due at time-of-service.

☐ **5** **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 not available for abortion care.
☐ I have private insurance ☐ I have Medicaid ☐ I do not have insurance

PAYMENT FOR SERVICES:
Payment is due at time-of-service, including co-pays and deductibles payments. We accept cash, credit cards (Visa, MasterCard, Discover, AmEx), checks (for some services), and money orders. Returned check fee is $20. Please note that all quotes are estimates; final appointment cost may change with 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.

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: _____

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

HOW MANY PEOPLE, INCLUDING YOU, DOES THE REPORTED INCOME SUPPORT? _____

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

☐ Client refused to report/does not want to be considered for sliding scale

CONFIDENTIALITY 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 a different address, you must contact your insurance company directly. We will send a statement to your address for any balance remaining after we have billed your insurance.

COVERAGE WITH INSURANCE

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, and policies regarding referrals, prior authorizations, co-payments, co-insurance, deductibles, and benefits. Please direct questions about coverage to your insurance plan administrator.

PAYMENT WITH INSURANCE

Co-pays, deductible payments, and co-insurance payments are due at time-of-service. You are responsible for any outstanding balance that remains unpaid by your insurance. If the insurance carrier denies your claim, you are responsible for the account balance in full and a statement will be mailed to your address.

INSURANCE USERS INITIAL BELOW:

_____ I request and assign all payments of authorized benefits be made on my behalf to Boulder Valley 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, including but not limited to screenings like contraceptive management, urinalysis, and certain injections. If my insurance does not cover a service or procedure, or if my visit is subject to a deductible/co-insurance, I am responsible for any unpaid charges. I understand that my provider may recommend additional services or tests and that they may result in additional charges.

_____ I understand that all outside lab charges (blood work, cultures, biopsies, and pathology) are not included with my visit and that the laboratory will bill my insurance separately. Women's Health does not know or control laboratory prices, and I, not Women's Health, am responsible for these charges.

INSURANCE POLICY INFORMATION

Primary Insurance Company Name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose policy is it? ☐ Mine ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company Name: _____

Subscriber/Member Number: _____ Group Number: _____

Whose policy is it? ☐ Mine ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other _____

Policy Holder's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

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:** _____