Creekside Center for Women

5330 Willow Creek Drive
Springdale, AR 72762

Kent A. Mason, M.D., F.A.C.O.G.
Michael P. Clouatre, M.D.
Ashley, E. Mason, M.D., F.A.C.O.G.

Voice 479.582.9268
Facsimile 479.973.9229
www.creeksideobgyn..com

Darrin D Cunningham,D.O.,F.A.C.O.O.G.
Greg Reiter, D.O., F.A.C.O.O.G.

FINANCIAL POLICY

PAYMENT & FEES Payment for your care is due at the time provided. The only exception to this policy is if we are contracted with your health insurance plan (see insurance below). The fee for an office visit will range from $90.00 to $300.00. If you have a pap smear, lab work or other services, there will be additional charges. Cash, Check, MasterCard, Visa, Discover and American Express are acceptable payment methods. We charge a $35.00 service fee for any returned check.

APPOINTMENT NO-SHOW If for any reason you are unable to attend your scheduled appointment, please call our office prior to the appointment time. We charge a $25.00 fee for failure to reschedule or cancel your appointment.

INSURANCE You are required to present your insurance identification card at the time of your appointment. We will file a claim for your services if we are contracted with your health insurance plan. Please, verify in advance that the physician you have chosen to see is contracted with your plan. Any co-payment, co-insurance, and/or deductible is due at the time of service. Please be prepared to pay this amount. A co-payment is normally a fixed dollar amount per office visit, identified on your insurance card. Co-insurance is the percentage of the bill that is the patient's responsibility. A deductible is a fixed dollar amount that must be paid before the insurance will begin to pay. Again, if you do not have your current insurance identification card or other acceptable proof of insurance, your visit will be considered private pay and you will be responsible for full payment at the time of service.

It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question any unpaid insurance claims. If you do not receive an explanation of benefits from your insurance within 60 days of your visit, please call them. After insurance has processed your claim, you will be billed for any remaining balance or in full for non-covered services. This amount is due upon receiving your statement. Your insurance makes the final determination regarding payment at the time the claim is processed.

WELLNESS BENEFITS A wellness, annual or preventative exam is defined as a visit without complaints. If you have insurance, our office will file your claim to reflect this. Should your visit include a problem that requires treatment, you may also be charged an additional office visit for the problem addressed, along with the charge for the preventative visit. Please be familiar with your insurance benefits before seeing the doctor. Our office will not change a diagnosis after the claim has been filed. If you have any questions, please feel free to talk with our insurance department or your physician.

REFERRAL If your insurance plan requires a referral, it is your responsibility to request the referral from your primary care physician to be sent to our office. Failure to obtain a referral when required can result in reduced benefits or non-payment by your insurance company, making you responsible for payment of the visit.

OB PATIENTS At the time of your pre-natal nurse visit, you will meet with a Patient Representative who will review our OB fees and prepare a payment plan based on the maternity benefits provided by your plan. You are required to present your insurance identification card at the time of this visit. If you do not have insurance, or your plan does not include maternity benefits, a deposit will be required. In all cases, payment of the patient portion is due in full by the beginning of the 7th month of pregnancy.

AFFILIATIONS NWA OB/GYN Associates, PLC dba Creekside Center for Women is an independent clinic owned by the physicians who practice here. However, some are affiliated with the Northwest Health System as investors in the Willow Creeks Women's Hospital where they are on staff and refer patients for surgery and deliveries.

I, the undersigned, have read and understand the financial policy as described above and agree to pay for any and all medical services including, portions not covered or denied by my insurance. Failure to pay in a timely manner will result in my account being turned over to an outside collection agency.

_____ _____

Patient Signature (or responsible party if minor) Date

MEDICAID WAIVER

Medicaid will only pay for services that they deem "necessary" and that are filed in a timely manner. If for any reason Medicaid does not pay your charges due to your lack of benefit knowledge or the correct procedures are not followed, you as the patient are responsible for all charges.

Your signature is required to insure that you are aware of your responsibilities. This is an agreement that you are willing to pay any charges that Medicaid denies.

If for any reason you do not present to the office with your Medicaid card before your scheduled appointment with the physician you will be asked to reschedule or you will be considered self-pay for the duration of care.

_____ _____

(Patient Signature) **(Date)**

_____ _____

(Witness) **(Date)**

TRICARE WAIVER

Tricare will only pay for services that it determines to be "reasonable and necessary" under 32CFR of the Congressional Federal Register Part 199, dated June 1, 1993-Final Rule. This law further states that even Tricare non-providers can only charge 115% of the Tricare allowable, unless the patient signs a waiver stating that they are aware of the 115% limit and the patient agrees to pay the additional amount.

Your signature is required each time that you are seen in our office. This will assure that you as the patient are completely aware that your are responsible for any amount that Tricare does not pay, even if our amount exceeds 115% of the Tricare allowable.

_____ _____

(Patient Signature) **(Date)**

_____ _____

(Witness) **(Date)**