Patient Name:_____

## Elisabeth Huelskoetter, M.D., LLC

### Financial Policy

I understand that I am expected to pay any deductible, co-insurance or co-payment at the time of my appointment. I also acknowledge that it is my responsibility to verify benefits with my insurance carrier regarding prior authorization and/or other important information prior to my appointment. I understand that full payment is due at time of service for all non-covered services or without proof of insurance coverage. I understand that regardless of insurance status, I am responsible for the payment of services. For surgery or pregnancy, Elisabeth Huelskoetter, M.D., LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

Elisabeth Huelskoetter, M.D., LLC will make every reasonable effort to obtain payment according to my coverage, yet regardless of the type of insurance coverage I have, I am ultimately responsible for paying my medical bills. If my insurance company rejects the claim or delays the payment, I will be responsible for all payments owed to Elisabeth Huelskoetter, MD, LLC. Should the unresolved balances be placed with an outside collection agency, I agree to pay all costs of collection, including attorney fees.

Elisabeth Huelskoetter, M.D., LLC accepts credit cards, cash and checks. I understand that additional charges are applied to my account for returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for telephone management services, for education materials and for other administrative expenses not covered by my insurance plan. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Elisabeth Huelskoetter, M.D., LLC.

Annual "Well Woman" exams are considered as preventative care and may not be covered by all insurance carriers. Medicare only pays a portion of this exam once every 2 years. I understand I am responsible for payment if the exam or a portion of the exam is not covered by my insurance.
Annual exams do not typically include problems I may be having. If I am experiencing problems, I may be required to reschedule another visit to address those concerns.

### Proof of Insurance and Referral

It is my responsibility to provide Elisabeth Huelskoetter, MD, LLC with accurate and updated insurance information at each visit. If at any time my insurance should change, especially during pregnancy, I will notify the office immediately to accurately file claims.
I'm also aware the some insurance plans require a referral from my Primary Care Physician and that failure to provide necessary referrals and/or authorizations will result in all charges for services becoming my sole responsibility.
If I do not have insurance, I will be considered a Private/Self Pay patient and am financially responsible for the total amount of services provided.

**By signing this agreement, I acknowledge that I have carefully read, understand and agree to the terms and conditions set forth above.**

Patient Signature_____ Date_____

Parent, Guardian or Legal Representative Signature_____

Employee's signature who reviewed intake of form_____