WOMEN'S PAVILION
OF SOUTH MISSISSIPPI

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

PAYMENT POLICY

Patients are expected to make payment in full for office services at the time of the visit. For your convenience, we accept cash, checks, VISA and Mastercard. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements will be made with one of our Patient Accounting Department. Patients who have insurances contracted with us are responsible for any co-payment or deductible at the time of service. Any balance remaining on one of these accounts after insurance payments have been received will become the responsibility of the patient. Accounts with delinquent balances could be reported to the credit bureau or turned over to our collection agency if little or no effort has been made by the patient to settle the amount owed.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize above office to use my medical information for treatment, payment, and healthcare operations, including submitting information to my insurance company, The Centers for Medicare and Medicaid Services, or the Division of Medicaid or its Fiscal Agent for the purpose of processing claims. I permit the following to be used in place of this document for all federal, state, and private commercial health insurance claims:

(1) Photocopy or other facsimile reproduction of this authorization, or
(2) Use of computer to indicate my signature is on file at above office, and/or
(3) Use of a computer to transmit my insurance claim by phone for processing.

▶ _____ ▶ _____ ▶ _____

Print Name | Lifetime Signature | Date

CERTIFICATION/AUTHORIZATION OF INSURED: I certify that the insurance information I have provided above office to be true and correct to the best of may knowledge. I authorize payment for services rendered to the doctors associated with the above office. I understand that the doctor(s) cannot accept responsibility for collecting my insurance claims or for negotiating a settlement on a disputed claim. I am responsible for payment of my account in full within the terms of the above payment policy. If I am under 18, the parent/guardian requesting treatment assumes responsibility. I understand that if my account should ever require action by a collection agency in order to collect the balance owed, fees charged by this agency may be added to the balance due on my account.

I authorize the doctors and WHNP(s) of above office and its designees to provide treatment. I further authorize labs, radiology centers, Pathologists and Radiologists who may interpret and report on diagnostic tests, and Anesthesiologist who will administer anesthesia during a scheduled procedure, to provide treatment, if such tests/procedures are ordered by my doctor(s). I authorize above office to release all or part of my records to:

(1) Physicians to whom I am being referred, and/or
(2) Any in- or out-patient facility where I am scheduled to receive treatment.

I authorize above office to use an automated telephone system and to use my name, address, and phone number; the name of my scheduled treating physician; and the time and placed of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize above office to disclose to third parties who answer my phone limited information regarding pending appointments, and to leave a reminder message on my answering machine.

▶ _____ ▶ _____ ▶ _____

Print Name | Lifetime Signature | Date