

Patients with insurance we participate with: Co-payments, deductibles, and co-insurance amounts are due at the time of service. We will file claims to all participating insurance companies for the remainder of the charges. Since your agreement with your insurance carrier is a private one, it is YOUR responsibility as a health insurance consumer to be aware of your coverage, policy restrictions, and to obtain verification that you are seeking care with a “participating provider” with your health plan.

Patients with insurance we do not participate with or self pay patients: Payment in full is required at the time of service. We will file claims to your insurance company so that you will get the reimbursement (if any).

Non-Covered Services: Any care not paid by your existing insurance company will require “payment in full” at the time services are provided or upon notification of such from your insurance carrier.

Assignment of Insurance Benefits:

I hereby assign all medical and/or surgical benefits to Southwest Florida Women’s Group and/or the physicians in this group. This assignment will remain in effect until evoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid or not paid by said insurance. I hereby authorize the use of this signature on all my insurance submissions whether manual or electronic. I hereby instruct the active insurance company that I have on file with Southwest Florida Women’s Group (SWFWG) to pay Southwest Florida Women’s Group by check or electronic payment. This is a direct assignment of my rights and benefits under my insurance policy.

ALTHOUGH EVERY EFFORT IS MADE TO CONTACT PATIENTS WITH TEST RESULTS, ULTIMATELY IT IS THE PATIENT’S RESPONSIBILITY TO FOLLOW UP REGARDING TEST RESULTS. IF YOU HAVE NOT BEEN NOTIFIED OF YOUR TEST RESULTS AFTER THREE WEEKS, PLEASE CONTACT THE OFFICE.

If your labs need sent to a lab other than Quest Diagnostics, it is your responsibility to let the nurse know before the test is performed.

By signing, I attest that all information provided is true and accurate and that I fully understand and agree to the above-mentioned policy. I have also received a copy of Southwest Florida Women’s Group Notice of Privacy Practices.

Patient Signature: _____

Date: _____