Financial Policy

The physicians and staff of Women's Care of Wisconsin, S.C. welcomes you to our clinic. Your health and well-being are our primary concern.

I hereby authorize Women's Care of Wisconsin, S.C. to furnish my insurance company(ies) and its (their) third party administrator(s), attorney, or legal representative all information which said parties may request concerning my treatment and care.

- **I am responsible for understanding my insurance plan and the financial responsibilities of that plan.**
- I am responsible for notifying Women's Care of Wisconsin S.C. of any/all insurance plans that I am covered by.
- I am responsible for paying any co-pay and/or outstanding balance that is due, at each visit.
- I understand that payment for non-covered charges is due at the time of service.
- If my insurance or demographic information changes during the course of my care, it is my responsibility to notify Women's Care of Wisconsin S.C. of any change in a timely manner.
- I understand that Women's Care of Wisconsin, S.C. expects payment from me for services within 21 days of my billing statement. I can pay using the following methods:
  - ✓ Cash
  - ✓ Check
  - ✓ Credit Card
  - ✓ Care Credit
- I understand that Women's Care of Wisconsin, S.C. utilizes a third party collection agency and my account may be transferred after unsuccessful collection attempts.

If you have any questions, please visit our website at **www.womenscareofwi.com** or call our knowledgeable staff at **(920) 729-7105.**

I have read and fully understand my financial responsibility for all services provided by Women's Care of Wisconsin, S.C.

_____I verify that I ☐ **do** ☐ **do not** have Medicaid (Badger Care) coverage.
Initials

Patient Name _____ **Date of Birth** ____/____/_____
(Print)

Patient /Legal Guardian _____ Date ____/_____/_____
(Signature)

Women's Care
OF WISCONSIN, S.C.

SUMMARY OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA regulations effective April 14, 2003 require your medical provider to share their written privacy practices with patients. Please understand that the privacy of your medical records has always been and will continue to be a priority to us. Below is a summary of how we will handle your medical information. Women's Care of Wisconsin's complete privacy notice is posted in the office and a copy is available for your records.

Women's Care of Wisconsin reserves the right to change the privacy practices described in the notice in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, notice of change will be posted in the office. At that time, you may request a revised copy of the privacy practices.

We can use your protected health information or "PHI" for the following purposes without your written consent or authorization.

- Treatment, payment or healthcare operations
- When required or permitted to do so by federal, state or local law
- When permitted to do so for matters of public health
- When required for law enforcement, judicial, or administrative proceedings
- When required to be given to a coroner or medical examiner
- When consistent with applicable laws, the release of necessary to prevent or lessen threat to public health or safety
- When necessary to comply with workers compensation requirements
- For organ or tissue donation
- For those involved in the payment of your care

Except for the situations listed in the Women's Care of Wisconsin Privacy Practices as summarized above, we must obtain your specific written authorization for any other release of your health information. You have the right to inspect and request a copy of your medical records. You have the right to request restrictions on certain uses and disclosures as outlined in the Women's Care of Wisconsin Privacy Practices. These requests must be in writing and forms are available for your use. We are not required to agree to your requests, but we will respond to any request in writing. If we agree to your written request, that agreement is binding on our part. You have the right to revoke authorization you have given at any time. Again, this must be done in writing. You also have the right to ask for a record of your health information disclosures.

I have read and understand these practices and my rights. I will be provided with a complete copy of the Women's Care of Wisconsin Privacy Practices should I request one.

Print Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

Authorization to Receive/Release Medical Information

Patient Name_____ DOB: _____

I authorize Women's Care of WI to communicate with, and **verbally** release my protected health information to the following individuals. This includes information about my appointments, care plan, and billing. I understand that this authorization will remain in effect until I revoke it in writing with Women's Care of Wisconsin.

_____ _____

Name of Individual Relationship to Patient

Please check information to be released to the individual noted above:

- ☐ Billing Information
- ☐ Appointment Information
- ☐ Medical Records (excluding HIV testing, behavioral health, and STI testing)
- ☐ STI Testing
- ☐ HIV Testing
- ☐ Behavioral Health

_____ _____

Name of Individual Relationship to Patient

Please check information to be released to the individual noted above:

- ☐ Billing Information
- ☐ Appointment Information
- ☐ Medical Records (excluding HIV testing, behavioral health, and STI testing)
- ☐ STI Testing
- ☐ HIV Testing
- ☐ Behavioral Health

____I am opting out of Women's Care of WI communicating with other individuals.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature Relationship to Patient

Women's Care of Wisconsin, S.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-920-729-7105.

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-920-729-7105.

繁體中文 **(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-920-729-7105。

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-920-729-7105.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-920-729-7105.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-920-729-7105 पर कॉल करें।

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-920-729-7105.

한국어 **(Korean)**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-920-729-7105 번으로 전화해 주십시오.

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-920-729-7105.

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-920-729-7105.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-920-729-7105.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-920-729-7105.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-920-729-7105.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-920-729-7105.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-920-729-7105.