# FINANCIAL POLICY

The providers and staff at Women's Care of Wisconsin welcome you to our clinic! Your health and well-being are our primary concern.

I hereby authorize Women's Care of Wisconsin 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.**
- If my insurance requires a co-pay, I am expected to pay 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 my course of care, it is my responsibility to notify Women's Care of Wisconsin of any change in a timely manner.
- I understand that Women's Care of Wisconsin 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 utilizes a third party collection agency and my account may be transferred after unsuccessful collection attempts.

If I have any questions, I can visit the Women's Care of Wisconsin website at www.womenscareofwi.com or call their 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.

_____ I verify that **I do** ❑ / **do not** ❑ have Medicaid (Badger Care) coverage.
(Initials)

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

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