Westlake GYN
1220 La Venta Dr., Ste. 205
Westlake Village, CA 91361
(805) 371-0770

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FINANCIAL POLICY

Thank you for choosing Westlake GYN as your health care provider. Please read this financial policy thoroughly. Due to the constant changes and demands of healthcare plans, we ask for your cooperation in providing us with the following:

- Your current and correct insurance information.
- A referral from your primary care physician if you require one.
- **Your co-pay is expected to be paid at the time you see your provider. You may be rescheduled if you cannot pay your co-pay or any outstanding balances from a previous visit that is solely your responsibility.**

We will file your claims as a courtesy. If your health plan fails to pay your claim in a timely manner, you will be responsible for the balance and contacting your health plan to follow-up. We will send you a statement notifying you of these circumstances. **Please do not ignore these statements.** If we fail to resolve any outstanding balances with you it could result in your account going to collections and thus you will be discharged from our practice. Westlake GYN will work with you, but we also need your help since this is your policy and with your insurance company. Thank you for your understanding.

SELF-PAY AND NON-PARTICIPATING INSURANCE

All self-pay and non-participating insurance patients must pay in full at the time of visit. You can file your receipt from us and try to seek reimbursement. We cannot file those claims for you. We invite most PPO plans but you must remember that with a PPO plan out-of-network benefits are applied to deductible, coinsurance, and out-of-pocket before they will pay any benefits. Until these amounts are met, we cannot add your plan to our system or file these claims. Contact your health plan for your personal options.

HIPAA *Health Insurance Portability and Accountability Act*

We will be using your health insurance information for your payment. A claim may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as diagnosis, procedures and supplies used.

- Cancellations will need to be arranged 24 hours in advance. If you fail to cancel your appointment within this allotted timeframe, your account will be assessed a **$25.00** "No Show Fee".
- Returned checks are subject to a $25.00 service fee
  Thank you for your cooperation.
- It is the patient's responsibility to review their insurance EOBs.

I have read, understand and agree to this Financial Policy.

Signature: ______________________________ **Date:** ________________________

Revised 3/16/09