Siloam Springs Women's Center

603-2 N. Progress Ave., Ste. 100 • Siloam Springs, Arkansas 72761
Phone: 479-524-9312 • Fax: 479-524-9627

Explanation of Patient Financial Policies

The physicians of Siloam Springs Women's Center are pleased that you have chosen our clinic for your OB and Gynecological needs. We strive to provide quality health care and want to ensure that you have been informed of our office financial policies.

Payment: Payment is due at the time services are provided. Siloam Springs Women's Center accepts the following forms of payment: cash, checks, money orders, Mastercard, Visa, Discover, and bank debit cards.

Insurance: Please present your insurance identification card at each visit to assure we have your most current information on file. Any co-pay is due at the time of service. The co-pay amount is usually on your insurance identification card. If the type of visit you have is not covered by insurance or counts toward your deductible, payment is due in full the day of service.

Referral: If your insurance plan requires a referral, please contact your primary care physician and request that a referral be sent to our office. Failure to obtain a referral when required can result in reduced benefits or no payment by your insurance.

Surgery Patients: Our office staff will contact your insurance company to verify coverage and estimate your financial responsibility prior to any planned surgery. Payment arrangements will be made based on this estimate prior to the date of your surgery.

OB Patients: On your initial visit you will meet with an office staff member who will prepare a payment plan depending on the maternity benefits provided by your insurance. If you do not have insurance or your plan does not cover maternity benefits, a deposit will be required.

If you are in the process of applying for Arkansas Medicaid for your pregnancy, inform our office staff. If your Medicaid coverage is not yet approved by the 20th week of your pregnancy, a deposit will be required and a payment plan will be established at that time.

Appointments/Schedule: If you have an urgent problem that you feel needs immediate attention, please call in advance to cut down on your waiting time in our office. The nurse will return your call and either work you in to the schedule or direct you where you need to go. We discourage walk-ins. A patient who walks in and wishes to be seen may be seen after the regularly scheduled patients and may receive an additional service charge which is not covered by insurance.

We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we will attempt to notify you beforehand. As a courtesy to other patients and staff, we ask that you call the office as soon as possible if you are unable to keep your appointment or are going to be late. Please give us at least a 24-hour notice whenever possible.

Statements: When we receive payment from your insurance, we will mail you a statement of the remaining balance due by you. If you are unable to pay the balance in full and have not already established a payment plan, contact our office to make payment arrangements. Failure to make regular monthly payments may result in your account being sent to a collection agency which can negatively impact your credit rating. Please stay in touch with our office to avoid this action.

Most importantly, we want to provide quality specialty healthcare to you as our patient. Please do not hesitate to call our office if you have questions or concerns regarding this or any other office policy.

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CONSENT TO TREATMENT AND TESTING

Consent to Treatment and Testing: I, the undersigned, patient or parent/legal guardian of the patient, hereby consent to the diagnostic testing and treatment services that may be performed, which may include, but are not limited to testing for infectious disease, laboratory procedures, radiology examinations, medical treatment or procedures, or services rendered under the general and specific instructions of my Physician. I understand that my Physician will perform services considered medically necessary according to his professional judgment. I authorize that during my treatment my Physician may either specifically or by previous arrangements request that other Physician(s) render professional services. Such services may include, but are not limited to, the services of a pathologist or radiologist.

Consent for Care by Supervised Students: I consent, or consent on behalf of my dependent, to receiving care from and/or having care observed by supervised students of authorized medical and nursing schools, colleges, or allied health programs affiliated with Siloam Springs Women's Center. **Yes** ____ **No**____

Information Provided:
Explanation of Patient Financial Policies: **Yes**____ **No**____
Notice of Privacy Practices: **Yes**____ **No**____ **(If No, note reason.)**
Patient Refused ____ **Received Previously** ____

Sharing Protected Health Information ("PHI") with family, friends and others who may be involved in my care: I request the following restrictions to my PHI.
No Restrictions ____ **Do not share my PHI with anyone**_____

(Please list the names of the individuals with whom we may discuss your Protected Health Information).

Name	Phone Number	Relationship to Patient

Other Specific Instructions: ____

Authorization, Release, and Benefit Assignment

Medicare Patients Only: I authorize Siloam Springs Women's Center as a holder of medical or other information about me, to release to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I hereby authorize Medicare to furnish to the Siloam Springs Women's Center any information regarding my Medicare claims under Title 18 of the Social Security Act. I request that payment of authorized Medicare benefits be made directly to Siloam Springs Women's Center on my behalf. I understand that I am responsible for any health insurance deductible, coinsurance, and non-covered charges.

Authorization for Releasing Medical Information and Assignment of Insurance Benefits: I authorize Siloam Springs Women's Center assignment of the insurance benefits otherwise payable to me, but not to exceed the balance due. I authorize Siloam Springs Women's Center as a holder of medical or other information about me, to release to my insurance company or its intermediaries any information needed for this or related insurance claims. I understand I am financially responsible for charges not covered by this authorization.

Agreement for Payment: In consideration of Siloam Springs Women's Center's agreement to render treatment and furnish supplies to me as a patient, I hereby agree to pay for all treatment, supplies, and services rendered to me whatever sums of money shall become due on my account. I understand that Siloam Springs Women's Center will file primary and secondary insurance as a courtesy, but I am ultimately responsible for payment in full for all balances.

Acknowledgement: I hereby understand and acknowledge that I have read each of the statements included in this Consent to Treatment and Testing document and have had each item explained to me to my satisfaction. Furthermore, I understand and acknowledge that all references to me as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible. I have received a copy of the foregoing and being the patient, the parent/legal guardian of the patient or being duly authorized by the patient, do agree and accept its terms.

Printed Name of Patient: ____

Signature: ____ **Date**_________ **Time**_______

Patient or Parent/Legal Guardian or Patient Representative

Relationship to patient, if not signed by patient: ____

ETHNICITY—Please check one		**LANGUAGE—Please check one**	
Hispanic or Latin		**English**	
Not Hispanic or Latin		**Spanish**	
Refused to report		**Indian**	
		Other	
RACE—Please check one			
White			
Asian			
American Indian or Alaska Native			
Native Hawaiian or Other Pacific Islander			
Black or African American			
Other Race			
Unreported/Refused to Report			

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Patient Demographic Information

Today's Date:	

Patient Information				
Patient's Name:			Name you go by:	
Mailing Address:			Date of Birth:	
City, State, Zip:			Social Security#	
Home Phone:		Cell:	E-mail Address:	

Patient's Employer Information			
Employer Name:		Work Phone:	
Employer Address:			

Guardian/Spouse Information (Please circle one)			
Spouse/Guardian Name:		Social Security #:	
Phone Number:		Date of Birth:	
Employer Name and Address:			

Emergency Contact (other than Spouse/Guardian)			
Contact Name:		Relationship:	
Phone Number:			

Referral Information	
Who referred you to our clinic?	

Insurance Coverage		
	Primary Coverage	**Secondary Coverage**
Ins. Company Name:		
Mailing Address:	XXXXXXXXXXXXXX	
City, State, Zip:	XXXXXXXXXXXXXX	
Telephone:	XXXXXXXXXXXXXX	
Member ID Number:		
Group Number:		
Name of Policy Holder:		
Relationship to Patient:		
Policy Holder Birth Date:		
Policy Holder Soc Sec #:		

Please have your photo ID and insurance cards available to be copied

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Patient Portal Access Form

Patient's Name: ____Date of Birth: _______________

The patient portal is provided in partnership with eClinicalWorks our software vendor. The data is provided through a secure web portal which uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses Secure Sockets Layer (SSL) technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Medical Advice and Information Disclaimer
The Siloam Springs Women's Center Patient Portal may from time to time include information posted in the form of news, opinions, or general educational materials that should not be construed as specific medical advice or instruction. The information posted within the Patient Portal should not be considered a complete medical record, nor should it be relied on to suggest a course of treatment for a particular individual. You should always seek the advice of your provider with any questions you may have regarding a medical condition or result and you should never disregard medical advice or delay in seeking it because of something you may have read on the Patient Portal.
Using the Patient Portal is entirely voluntary and will not impact the quality of care you receive from Siloam Springs Women's Center should you decide not to use the Patient Portal. This office will not condition treatment or payment for health care on whether or not you use the Patient Portal or agree to this disclaimer.

Please check one of the following options, date and sign.
_____ I am signing up for patient portal access using the email address provided below:

Email:____

_____ I decline patient portal access at this time.

Signature: ____ Date: _____________________