All WOMEN'S HEALTH
Tania N. Morgan-Bowen, MD, MPH

PAYMENT POLICY

All Women's Health is committed to providing our patients with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding our payment policy.

All services are provided for a fee for service basis unless you are associated with a managed care plan. In the case of a managed care plan you will be required to pay your co-pay only at the time of your visit. Payments for office visits, insurance co-payments and deductibles are expected when services are rendered. There are companies which will not reimburse for contraceptive management or annual physicals. Please check your benefits with your company prior to scheduling those types of visits. We accept cash, personal checks, VISA and MasterCard.

MEDICAID PATIENTS
Please bring a copy of your Medicaid card to each visit; otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your 12 authorized visits. Please be aware that if you have a Primary Care Physician assigned to you, you are required to have a referral number from that office. Also, if you are currently pregnant, it is your responsibility to make sure you coverage type has been changed to "Pregnancy".

INSURANCE PATIENTS
Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to prepay unmet deductible and co-insurance prior to any surgery performed or following emergency services.

AUTHORIZATION FOR SERVICES
I understand that the signature below serves as authorization for services rendered by Dr. Tania Morgan-Bowen for the patient listed below. The release of information is necessary to file insurance and assign benefits. I understand that I am financially responsible for any balance not covered by the insurance carrier. A copy of this signature is as valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION
The signature below serves as authorization to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

_____	_____	_____
Print Patient's name	Patient or Guardian Signature	Date