8070 E. Morgan Trl, Ste. 120 Scottsdale, AZ 85258

Phone: 480-825-7941 Fax: 480-825-7945

Payment Policy (Non-Medicare)(Non-Self Pay)

We are committed to providing top quality care to our patients at reasonable prices. Patients who do not pay for care drive up costs for those who do. We believe this is unfair. Therefore, we require that all patients adhere to the following strict payment policy.
All patients are required to pay any co-payment amount and all past due balances at each check in. In addition, at each visit, all patients are required to either: Present a valid insurance card - OR - Pay for services prior to receiving services.
Once an account is turned over to a collection agency, we incur significant additional costs and we will not be able to work with you on payment arrangements. Furthermore, we will not be able continue seeing you as a patient if you do not pay your balance.
Patients are responsible for all charges indicated as patient responsibility by their insurance companies. Patients are solely responsible for knowing their coverage limitations and their financial responsibility *before* accepting diagnosis or treatment.

Patients are responsible for charges stemming from companies who provide lab work, imaging, anesthesia, cord blood collection, surgical assistance or other tests or services related to their care. Patients are responsible for all charges they incur by these companies, and we have no influence over their billing practices, even though some services are performed within our offices for your convenience. Patients who receive diagnosis or treatment in our office accept responsibility for all charges which may result from leaving samples of urine, saliva, blood, or other tissues collected by a provider (e.g. biopsy). We will not pay the bill you may receive from these companies for services they perform in conjunction with your care. It is your responsibility to be informed before you leave a sample or consent to any diagnosis or treatment our providers may provide.
Patients having a positive patient account balance will receive monthly statements. If no payment is received within ninety days from your date of service, patient's account will be turned over to a collection agency and subject to late fees or interest. A patient's credit rating will be impacted.

I, the undersigned, hereby acknowledge that I have read and agree with the above payment policy. I understand and agree that I am responsible for all charges deemed my responsibility and I authorize Serenity Women's Care, to take the above actions to collect payment. I agree that I am responsible for any late fees, interest fees, collection fees, or legal fees related to collecting payment for my charges. I further authorize Serenity Women's Care, to report me to a collection agency or to credit agencies, if required. I understand that Serenity Women's Care, submits insurance claims on my behalf, if applicable, but that I am ultimately responsible for payment of all charges.

I authorize Serenity Women's Care to bill the insurance company for any services rendered. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim.

Signed _____ Dated _____

Patient Name _____ Date of Birth _____