Please List Name/Relationship of who referred you to us________ ________________________

FINANCIAL AND INSURANCE AGREEMENT

A mutual understanding of trust between the patient and the office is most desirable. Our staff is available to assist you in any way in maintaining this relationship. Please feel free to discuss fees and methods of payment with our business office. Various methods of payment including cash, select credit cards (Visa, MasterCard, Discover, American Express) and third party payment by insurance.

Insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance carrier. We will be happy to assist you by filing your insurance claim for you and answering any details that the insurance company may require. However, we cannot be responsible for payment by the insurance company. The responsibility for payment belongs to the patient.

Please remember that no insurance attempts to cover all costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pays, or any other balance not paid by your insurance company at the time of your visit.

On managed care contracts, we will abide by the provisions of the contract in filing your insurance and taking the necessary write-offs as indicated by each plan. However, It is your responsibility to obtain a referral on every visit and to pay any co-pays and deductibles on the day of service. We are not responsible for obtaining your referral for you. You must obtain the referral before your appointment, or you will be asked to reschedule the appointment until such time as you obtain the referral before we can proceed with filing your insurance for you.

PATIENT'S RESPONSIBILITY: I am responsible for all charges regardless of insurance coverage. It is my responsibility to provide up-to-date insurance information on a continual basis; I will pay for ALL charges in full if I do not provide up-to-date insurance information. I will pay for all charges in full if I have any form of TennCare other than BlueCare. I agree to pay all collection costs or attorney fees if this account is turned over for collection. I have read, understand, and agree to the above policy for this office. I hereby assign to LifeCircle Women's Healthcare any medical reimbursement benefits under my insurance policy. I authorize the release of any information acquired during the course of my treatment to my insurance company and to other medical providers to which I may be referred for treatment.

Patient/Responsible Party Signature____

Responsible Party's Relationship to Patient_________________________________

Date________________________

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature____ **Date**_______________