PAYMENT AGREEMENT

Women's Medical Center of Meridian, P.A.

I do hereby confirm that all the information that I have supplied to Women's Medical Center of Meridian, P.A. (WMC), is true and correct, to the best of my knowledge.

I also agree to notify WMC of any changes in the information I have provided regarding either health status or general patient information, and changes in insurance information on a timely basis or upon my next scheduled appointment with WMC.

I hereby acknowledge that I am ultimately responsible for the full payment of any and all fees or charges for services provided to me by WMC, and that filing of insurance claims with any health care insurance coverage I may hold is a courtesy to me and does not in any way relieve me of financial responsibility for any balance remaining after insurance payments, **including any amount that exceeds my insurance company's usual, reasonable, and customary rate.**

I understand that WMC requires that **ALL BALANCES** be paid **IN FULL** within thirty (30) days of treatment. I also understand that if I disagree with the payment made by my insurance carrier, I will contact the carrier directly to discuss those concerns.

I understand that if my primary care physician has not authorized this visit and I have no referral number, the services I receive may not be covered by my health care benefits plan. In that case, I will be responsible for payment in full for services rendered. **(NOTE: This paragraph applies only to patients who require a referral number from their PCP.)**

I understand that my insurance plan may not cover certain procedures and that if I request non-covered services, I will be financially responsible for those services and agree to pay any and all non-covered fees and charges.

I am aware that my co-pay, co-insurance, and/or deductible is due at today's visit.

A $25 fee will be charged for missed appointments not canceled with your doctor's receptionist at least 24 hours before the appointment.

A $25 fee will be charged for all returned checks.

Should my account ever be turned over to a collection agency, I will be responsible for any and all collection costs, including attorney fees and any court costs.

_____ _____

Signature **Date**