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Financial Agreement for Well Woman Care

Care may include any of the following:

- Comprehensive health history intake
- Screen for dis-ease and assessment of vital organs
- Facilitation of preventative care
- Alternative healing methods for ailments within the range of normal, including but not limited to, herbal and homeopathic remedies
- Physical exam
- Pap Smear (cervical cancer screen)
- STI screening & counseling
- Clinical breast exam and counseling
- Nutritional counseling, including:
  Diet analysis and strategizing
- Reproductive health counseling, including:
  Sexuality
  Preconception and Conception
  Contraceptive Options *(Mandala Midwifery cannot prescribe hormonal allopathic birth control.)*
  Fertility Awareness Based Method
  Menopause
- Identifying trauma associated with the Conventional Medical Model of Care.
- Referrals to local alternative practitioners and medical doctors as needed.

The fee does not include fees for laboratory tests, physician consultations, herbal or homeopathic remedies.

Payment with Insurance

If you have a PPO health insurance, you are able to obtain reimbursement for services from providers who are "out of network." We use Larsen Billing Service (LBS) to manage the insurance billing. LBS submits the appropriate forms to your insurer and follows up with any claims.

By entering into this contract, you authorize Mandala Midwifery and LBS to release health information to your insurance company or health carrier for the purpose of processing your claims.

Mandala Midwifery and LBS may bill your insurance company or health carrier for the following services related to your care including, but not limited to: **Well-Woman visits and lab work.**

The standard fee for Mandala Midwifery Well-Woman Care is $250 per visit. The client is responsible for paying Mandala Midwifery a deposit of $250, regardless of insurance reimbursement. Clients are required to pay the full deposit on the day of the visit.

If the insurance company accepts your claims, you will be reimbursed according to your insurance plan. If the client puts forth a payment incorporating a sliding scale discount, any insurance reimbursements will first go toward the discount for services to cover the deposit for the standard fee for services. When the deposit for the standard fee for services has been met, the remaining insurance reimbursement will go to the client. Your reimbursement cannot exceed the amount put forth to Mandala Midwifery. Any reimbursement from the insurer in excess of the deposit will go to Mandala Midwifery to cover the costs associated with insurance billing. This is possible because LBS bills insurance and health carriers by itemizing services in accordance with the insurer's claims payment structure, which may require billing the payor in excess of the standard fee. It is illegal for clients to make money off of insurance claims.

If the insurance company denies your claims, you are responsible for continuing to pay Mandala Midwifery the entire deposit to cover the standard fee for services, less, if applicable, the sliding scale discount.

If the insurance company pays Mandala Midwifery directly, we will send you the appropriate reimbursement. Your

reimbursement amount will be affected by your assigned co-payments, any deductibles applied to the claims, independent of payments from the insurers. The billing service fee will be deducted from the insurance reimbursement.

If the insurance company pays you directly, which is not uncommon, you agree to cooperate with LBS. They will determine how much of the reimbursement should be sent to Mandala Midwifery, taking into account co-payments, deductibles, and the LBS fee; and how much, if any, is yours to keep. In this situation, you agree to reimburse Mandala Midwifery immediately. Any unpaid balance remaining 30 days after the insurance reimbursement was sent is considered delinquent and is subject to a 1.5% monthly interest charge. Any unpaid balance remaining 90 days after the insurance reimbursement was sent will be reported to a collection agency and will negatively impact your credit rating.

You, the client agree to pay a fee for the insurance billing services of Larsen Billing Service. This fee shall be an amount equal to 8% of collections from billing, or $15.00 per client, whichever is greater. If the collections from billing exceed the deposit amount, the 8% fee will be paid by Mandala Midwifery to LBS. The client will not be responsible for paying the 8% on any amount the provider receives that exceeds the deposit.

Self-Pay

If your insurance does not cover our services, or you have no insurance, you will be considered self-pay. The standard fee for Mandala Midwifery Well-Woman Care is $250 per visit.

Additional Fees Refundable Deposit

If additional fees are acquired, such as labs, herbs, homeopathics, billing service, etc., payment for those fees are due in full at the visit. If the cost of the fees are unknown or undetermined, a separate Additional FEES refundable deposit in an amount exceeding the anticipated cost is due at the visit. Any unused funds will be returned. If the additional fees exceed the amount put forth to cover the cost of the additional fees, you will be billed accordingly. It is not required to pay the Additional Fees refundable deposit if no additional fees are acquired.

Refund Policy

Payments are non-refundable.

Sliding Scale Option

The following guideline is suggested to determine a sliding scale discount for each visit of Well Woman services. A package of 5 visits will receive a 10 % discount. **Please check appropriate box for your familial income.**

❒ Annual income under $20,000; the total put forth by the client is $50
❒ Annual income between $20,000 - $30,000; the total put forth by the client is $75
❒ Annual income between $30,000-$45,000; the total put forth by the client is $125
❒ Annual income between $45,000-$80,000; the total put forth by the client is $225
❒ Annual income above $80,000; the total put forth by the client is $250

Total put forth by the client for Well-Woman Midwifery Services: $_____, Check #_____, Date_____.
Additional Fees Estimated: $_____. Additional Fees Deposit: $_____, Check #_____, Date_____.

All parties agree to this Financial Agreement.

Client (Please Print)	*Signature*	*Date*

Midwife (Please Print)	*Signature*	*Date*