DELMED HEALTH
WOMEN'S HEALTH SERVICES

431 Savannah Road, 1st Floor
Lewes, DE 19958
Phone: (302) 644-9080
Fax: (302) 644-9088

Financial Agreement

Please Print and Complete All Information

Name: _____ DOB: _____

DELMED HEALTH IS **NOT** RESPONSIBLE FOR ANY BILL COMING FROM THE LAB. You will be responsible for any additional lab fees, radiology fees, and co-pays according to your insurance plan.

Authorization to Pay Insurance Benefits:
I hereby authorize all insurance payments to be paid directly to DelMed Health, under the terms of my insurance policy with respect to services provided for myself and/or my dependents.

_____ Please Initial Here
I understand that **I am financially responsible** for any balance of charges not covered by my insurance **including deductibles, co-payments, and co-insurances.**

_____ Please Initial Here
I understand that **my co-payment is due at the time of my visit**. If it is not paid at the time of my appointment, there will be a **$5.00 administration fee** applied to my account each month until my co-pay is paid in full.

_____ Please Initial Here
I understand that if no payment is made within 3 months of when the insurance payment is received, my account will be sent to collections. This will also include a **28% collection agency** fee, **$12.00 postage fee**, and any other associated fees that will be due to the collection agency and to DelMed Health. I will also be **dismissed** as a patient from DelMed Health until my account is paid in **full**.

_____ Please Initial Here
If a budget agreement is made with DelMed Health it will require a financial agreement signed by myself and the billing department. According to this agreement all balances must be paid in **full** within **4 months** or my account will be sent to collections. This will also include a **28% collection agency** fee, **$12.00 postage fee**, and any other associated fees that will be due to the collection agency and to DelMed Health. I will also be **dismissed** as a patient from DelMed Health until my account is paid in **full**.

_____ Please Initial Here
I understand that if I cancel that same day of my appointment (under 24 hrs), or do not show up to my appointment, a **NO SHOW FEE** of $25.00 will be charged to my account and are subject to DelMed Health's financial policies.

Authorization to Release Medical Information:
I authorize DelMed Health to release any medical information necessary to process this claim and/or coordinate my care.

Consent for Treatment:
I give my consent to DelMed Health, its staff, and related associates to provide services considered necessary and proper for my diagnosis.

My initials and signature consent to all of the above

Signature: _____ Date: _____
Signature needs to be of parent or guardian if patient is under 18 years of age.