Patient Request Do Not Bill Health Insurance **(OMNIBUS Final Rule 2013)**

In response to your request Great Plains Women's Health Center will not bill your health insurance carrier for services rendered when requested. **The request must occur when the service is rendered**. This is a legally binding document on both parties and as a result will be signed by both parties. The guidelines and responsibilities for this process are listed below.

Patients Responsibilities

I understand and agree to the following:

1. I am responsible for informing other facilities that render services associated with this visit. *(example- the hospital or laboratory where a procedure or test is billed)*

2. Payment in full must be made within 30 days from the date of service. Failure to comply will result in Great Plains Women's Health Center submitting a bill for the charges for this visit to my insurance carrier. The same applies for a payment made by check that does not clear within the 30 day time frame.

3. If at any point I decide to have my insurance billed, I am responsible for notifying Great Plain Women's health Center office.

4. I understand that if the balance for is not satisfied in accordance with this agreement and/or it falls outside the time frame for submission to my insurance carrier, the bill for this visit will be sent to collections

Great Plains Women's Health Center Staff Responsibilities

I have completed the following:

1. Reviewed the guidelines and responsibilities with the patient as indicated in internal policies and procedures.
2. Executed this document and placed a copy in the medical record.
3. Ensured that all registration and billing systems are updated as required based on the internal policies and procedures.
4. Ensured that all actions taken in conjunction with this agreement are documented in the patients account.

Date of Service _____ Provider Name _____

The guidelines and responsibilities above have been reviewed by both parties on _____.
Both parties agree to abide by the terms of this agreement.

_____ _____
Patient Name- printed GPWHC Representative Name-printed

_____ _____
Patient Signature GPWHC Representative Signature

Restriction Terminated _____ _____
Date Patient Signature