ADDENDUM – WOMEN'S CARE FLORIDA - NORTH FLORIDA OB-GYN FINANCIAL AGREEMENTS – HEALTHCARE EXCHANGE COVERAGE

In the best interest of the covered patient as well as Women's Care Florida – North Florida Ob–Gyn and to avoid unexpected financial expenses for you we make every effort to verify the insurance coverage, benefits, and deductible status.

During this process we have determined that some of the Health Plan System Sites are not always up to date and we are unable to obtain accurate information therefore resulting in unexpected claim denials and/or retraction of paid claims.

For this reason we have found it necessary to require monthly proof that the insurance premium you have purchased has been paid for the month services are being provided.

We regret that this requirement is necessary and we apologize in advance for any inconvenience that this has caused you. Thank you very much for your understanding and cooperation.

In addition to my understanding of the FINANCIAL AGREEMENT of NF OB-GYN, I ________________________________ understand and agree with the following requirements regarding my current Health Insurance Coverage:

- My Healthcare Exchange product requires payment for my insurance coverage by the 1st of every month to remain active for the month. My health insurance coverage will lapse into a grace period and/or terminate/expire if I do not make my payments by the designated due date each month. Grace period category is considered "uninsured" or "no-insurance" by NF OB-GYN.
- During the course of my care and each month, I will provide proof to NF OB-GYN, of my **monthly** insurance plan payments. Otherwise, I will be considered uninsured and fall under NF OB-GYN's uninsured/private-pay guidelines. Failure to provide this proof of monthly insurance payments could result in rescheduling of appointments.

Patient Name: _______________________________________ Date of Birth:________________

Guardian or
Patient Signature: ____________________________________Date:_______________________

NF OB-GYN
Witness Signature:____________________________________Date:_______________________