WOMEN'S HEALTH CARE ASSOCIATES P.A.

Debra Hardy-Cartwright, M.D. F.A.C.O.G.
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OFFICE POLICY AND PROCEDURES

Our office adheres to a late policy of 15 minutes. If a patient arrives 15 minutes or later for their scheduled appointment, they will be asked to reschedule.

Our office requires at least 24 hours notice for cancellation. If an appointment is not cancelled, the patient will be charged a $25.00 'No Show' fee. If you believe that you have been charged a 'No Show' charge in error, then you have 30 days in which you can dispute this charge. Please note that the $25.00 'No Show' fee must be paid before your next visit.

Medical record requests require 14 days to process. As mandated by Maryland State Law there is fee of $16.46 plus $0.54 cents per page, that must be paid prior to processing your request.

Co-payments must be made prior to the patient being seen. This is required in the terms of your contract with your insurance company. Any amounts that are applied to the patient's deductable are due and payable prior to the patient's next visit or within 30 days after we receive notification from your insurance company, whichever comes first.

Obstetrical patients are required to pay in full by the 28th week of pregnancy any part of our fee classified as patient responsibility by the insurance company. We request notification of our office immediately if any changes in insurance occur during the pregnancy.

Patients must present appropriate insurance information or the visit must be paid in full at the time of the appointment. If your card does not have the appropriate information listed, then you will be responsible for your visit.

Prescription refills require 48 hour notice to be filled. All information must be given to the nurse or receptionist during business hours. Please leave a detailed message including medication name, dosage, pharmacy phone number, FAX number and any allergies.

I authorize release of my medical records to my insurance company, if necessary, to process my claim. I understand that this authorization may be revoked by me , in writing at anytime.

I authorize WHCA, P.A. (Women's Health Care Associates, P.A.) to obtain medical records relating to my care from previous providers of this service.

Name of patient:_____
(Print Name)

Name of Legal Guardian (if applicable): _____
(Print Name)

Signature of Patient or Legal Guardian: _____ Date: _____