Welcome to our Practice

Thank you for scheduling an appointment with Dr. Molland.

Following is some information that will help familiarize you with our practice.

Location: 601 N. Tom Green Ave., Odessa, Texas 79761
Phone Number: 432-334-7888

Business Hours
Monday-Thursday 8-12pm and 1-5pm, Friday 8-12pm. We are closed for lunch from 12-1:30pm.

Payment Policy
It is our policy to collect the appropriate payment due before service is rendered. This may include your co-payment, deductible, and/or coinsurance. We accept MC, Visa, Care Credit, and Cash. We do not accept checks.

I am enclosing a patient registration form, financial policy, and information regarding preventative visits to be completed prior to your visit. These forms may be returned using the following methods:

- Email to info@drmolland.com
- Fax to 432-334-9949,
- Mail forms to office address provided

If you have not already provided it us prior to your scheduled visit, please bring the following information to your visit:

- Insurance card(s)
- Driver's License
- Patient Registration Form
- Financial Policy Form
- Well Woman Exam Form

We appreciate you selecting Dr. Molland for your medical care and we will work diligently to serve your needs.

Sincerely,

The Women's Center of the Permian Basin, PA
John R. Molland, M.D.

Patient Information

Last Name_____ First Name_____ Middle Initial_____

DOB_____Sex_____Preferred Pharmacy_____Location_____

Race: White
Asian
Black/African American
Native Hawaiian/Pacific Islander
American Indian/Alaska Native
Other Race
Unknown
Declined

Ethnicity: Not Hispanic or Latino
Hispanic or Latino
Unknown
Declined

SS#_____Primary Language_____Marital Status_____DL#_____

Physical Address (No PO Box)_____City_____Zip Code_____

Mailing Address_____City_____Zip Code_____

Phone: Home_____Work_____Cell_____Primary_____

Preferred Method of Communication (circle one): Home Work Cell

Emergency Contact Name and Number_____

Employer Name_____Occupation_____Employer Phone_____

Primary Insurance

Insured Last Name_____ First Name _____ Initial _____

Relationship to Patient _____

Insured Birthdate _____ Insured Soc. Sec # _____

Address _____ City _____ State _____ Home/Cell Phone_____

Insured Party Employed by _____ Business Phone _____

Business Address _____ City _____ State _____ Occupation _____

Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Subscriber/Member ID Number _____ Group Number _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and I authorize payment directly to The Women's Center of the Permian Basin, P.A. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Women's Center of the Permian Basin, P.A. may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

The Women's Center of the Permian Basin, P.A.
John R. Molland, M.D.

Financial Policy

To reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office business manager. We are dedicated to providing the highest quality of care and service to you. We regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. We hope you will find this information helpful.

Insurance

We accept most commercial insurance plans including Blue Cross Blue Shield, United Healthcare, Aetna, Cigna and many additional plans. We have made prior arrangements with many insurers and health plans to accept assignment of benefits. We will bill your primary insurance only for the plans for which we have an agreement.

Changes in Insurance Coverage

If there is any change in insurance, it is your responsibility to make us aware immediately. Delays in communicating these changes may result in transferring all unpaid balances directly to the patient.

Insurance Cards

We ask that you bring your insurance card with you to every visit. If you do not have your insurance card, you may be asked to pay for the visit and sign a waiver transferring payment responsibility to you.

Office Visits

We will require you to pay the authorized co-payment, coinsurance, and/or deductible amounts at the time of your visit.

Well-Woman and/or Annual Exams

Many insurance companies process these visits as preventative care, however, there may be some companies that do not cover certain types of visits. For additional information, please see the 'Annual Well Woman Exam' form that is included in the new patient packet.

Surgical Fees

We will estimate the out-of-pocket amount for your surgical procedure. This amount is due prior to the scheduled surgery date. We will only estimate the portion due to the surgeon and excludes the facility fees, anesthesiology, lab, etc.

Obstetrical Care Payments
All OB benefits are verified prior to your initial visit. We will estimate your out-of-pocket cost based on copayment, coinsurance, and deductibles. A payment schedule will be prepared and reviewed with you at your initial OB visit. In the event there are changes to your insurance, any additional amounts due will be collected prior to your next appointment.

Minor Patients
For all services rendered to minor patients 17 years or younger, we will expect the adult accompanying the patient and/or the parent or guardian to make the required payment at the time of visit.

Payment
We accept MasterCard, Visa, Care Credit, and Cash. We do not accept personal checks and/or company checks.

Medical Record Fees
There is a minimum charge of $25 for medical record requests. In addition, there is a $40 fee for all FMLA and/or Disability forms. Please keep in mind, the average time to complete these forms are 15 days from the date of request.

Thank you for taking the time to understand our financial policies. If you have any questions or concerns about the financial aspects of your relationship with our office, please feel to speak with our business manager.

I have read and understand the financial policy of the practice and I agree to be bound by the terms. I also understand and I agree that the practice may amend such terms from time to time.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date

The Women's Center of the Permian Basin, P.A.
John R. Molland, M.D.
601 N. Tom Green Ave.
Odessa, Texas 79761
(432) 334-7888

I have been informed and I understand that there are non-covered services, which are excluded from my insurance plan. I further understand that these non-covered services are not an allowable expense; therefore, I agree in advance to accept full financial responsibility for all costs associated with the non-covered medical services. In addition, I understand and agree that these non-covered medical services will not be filed with my insurance company.

Patient Signature:_____ Date:_____

Important Information for our Patients Regarding Annual Well Woman Exams

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by Federal law and the American Medical Association (AMA). These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of Preventive and Screening services.

The Well Woman or Preventive Medicine charge for our practice includes:

- A complete history and examination in addition to a breast and pelvic exam. There will be questions about other medical conditions and counseling on risk factors such as sexually transmitted disease prevention, diet and exercise, stress management, smoking cessation, self breast exams, birth control, menopausal symptoms and hormone replacement therapy.
- Pap Smears will be taken yearly unless you have had a hysterectomy. In that case, the pap will be collected every 2-5 years depending on your physician's recommendation. Please be aware that some insurance companies will not pay for a "Well Woman" exam unless you have a pap smear test. **Please know your benefits**.
- Appropriate labs (such as hormone or STD tests) or diagnostic tests (such as mammograms) may be ordered and **will be billed separately**. Please know your benefits concerning additional labs or tests as we do not verify for other entities.
- Immunization administration, vaccine/toxoid products and other procedures are not included.

The annual exam is preventive and the appointment is reserved for a preventive check up. Discussions about problems and conditions for which you are already being treated that are ***under control*** are considered an integral part of the Well Woman exam and cannot be billed as a "problem/sick visit" under Federal compliance Rules.

Our providers cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment by billing an annual exam as a "problem or sick visit" when no other medical concerns were presented or evaluated. If a separate problem is identified during the course of youe Annual Exam that takes priority over the Annual, it will be billed as a "problem/sick visit." Some patients expect to receive the annual exam and the problem visit at the same scheduled appointment, but these are two separate types of appointments and they will be treated as so.

While we regret that billing guidelines and insurance carriers may not pay for more of your annual exam, it is preventive by intent. You as the patient and insured will be responsible for payment as dictated by your insurance plan for all co-payments and deductibles at the time of service.

Providing you with high quality healthcare remains our first priority. We thank you for choosing us to assist you with your healthcare needs.

Respectfully,

The Women's Center of the Permian Basin,P.A.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date