Philadelphia Women's Center

Fees and Financial Responsibility

Philadelphia Women's Center (PWC) is fully committed to providing the highest quality care to the widest population possible, while maintaining a financially viable facility. We are committed to a pro-choice ethic that recognizes that women of diverse economic backgrounds should have access to the same health care and counseling services in the highest quality, compassionate environment.

Listed on the back of this form, please find the usual and customary rates for services at PWC. In an effort to provide services to the diverse economic population the wider community, PWC offers a sliding fee schedule for care. In recognition of the hardship of the sudden, unplanned cost of abortion care, you may be entitled to a reduction of our usual fees if we determine it is appropriate based upon your ability to pay. We offer basic reduced fees for patients with no health insurance coverage or who are otherwise in financial need. Further discounts and assistance may be available in cases of extreme need.

In support of our goal to provide the highest quality care in the most efficient manner at the most affordable price, it is essential that all patients pay for services provided. If the patient does not receive all of her scheduled services, whether by the patient's choice or the decision of PWC for medical or other reasons, the patient is responsible for payment of all services she received. If the patient is rescheduled to complete her care on another day, the fees she pays on the day she was rescheduled will be deducted from the final cost of care.

If for any reason your procedure is not completed, you will be billed only for those services rendered. The following charges *may* be retained by Philadelphia Women's Center for services provided:

Ultrasound: $125
Patient Education: $25
Lab work: $50
Physician consult/exam: $40

By signing below, I certify that I require financial assistance to pay for services provided to me by the Philadelphia Women's Center. I further certify that I have read, fully understand and agree to the above policy and the fee schedule set forth on this page.

Patient Signature Date

Parent / Guardian Signature, if applicable Date

Staff Witness Date

Revised 11/21/2011