

Our Financial Policy

June, 2009

We would like to take this time to review with all our new and existing patients, our office policies and patient responsibilities. Please read and sign the bottom verifying you understand our office policies.

Insurance cards must be presented at each and every visit. Any changes in address, employment status, or phone number must be communicated to the staff at time of check in.

It is your responsibility as the insurance holder to know what your insurance covers in regards to office visits, testing, etc. Please be familiar with what your copay or deductible may be.

A charge of \$25.00 for office visits / \$50.00 for procedures and surgeries will be assessed for all no-show or cancelled visits with less than 24 hour notification - NO EXCEPTIONS. This fee will be collected at time of next visit.

An up front service charge of \$15.00 is required for filling out and processing any paperwork, including but not limited to:

- Disability
- Worker's Compensation
- FMLA
- No Fault

Forms will not be processed unless payment is received.

**All copays are due at time of service.
Services will not be performed unless copay is collected.**

Patient responsibility balances exceeding \$500.00 over 120 days, will be discharged from care.

There is a \$20.00 fee for all returned checks.

Respectfully,

AWM Physicians

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Associates For Women's Medicine to furnish information to insurance carriers concerning my illness and treatments.

I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by Public health law for copying of medical records will be immediately due and payable. In the event that my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

I have read and agree to the Financial Policy.

Patient Signature

Date

Patient Print Name

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____

Print Patient Name if Minor: _____