

## Our Financial Policy

Thank you for choosing us as your health care provider. A successful women's health care relationship requires mutual understanding, respect and confidence. We ask that you **carefully read** and sign the following Financial Policy.

**\*\*We require a copy of All insurance cards and ask that you present them at Each visit.\*\***

**Participating Insurances** - We participate with many insurance companies. Co-pays are due at time of service. If a co-payment is not made at the time of service, a **\$5.00 service charge** may be added.

**Non-Participating Insurances** - Payment in full is required at time of service. As a courtesy, we can bill your insurance.

**For All Insurances** - Please review your Benefit Listing Summary. Well Woman or Annual exams are usually considered as preventative care. This is often not covered by many insurance policies. We can keep a copy of your Benefit Listing Summary on file for you.

**For Medicare** - There is coverage for a breast, pelvic exam and pap smear - based on certain criteria. However, Medicare does **not** cover a Well Woman preventative exam.

**Associates for Women's Medicine has highly trained insurance billers that can assist you with questions and billing. You may contact the billing department at (315) 423-9722.**

**Obstetrical Patients** - After your first visit to confirm your pregnancy, you will be given an appointment with our obstetrical billing staff. We will go over your insurance coverage and benefits and determine your financial obligation to us for your pregnancy care.

**Returned Checks** - There is a \$20.00 fee on all returned checks.

**Medical Record Copies** - There is a fee for medical record copies in certain specified circumstances.

**Payment Methods** - Cash, checks, Mastercard or Visa are accepted. You also have the ability to use the online bill pay option through our website: <http://www.afwomensmed.com>

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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Print Name

Parent/Guardian Print Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Print Patient Name if Minor: \_\_\_\_\_