Associates for Women's Medicine

315.423.9722

Our Financial Policy

- Insurance cards must be presented at each and every visit
- It is your responsibility as the insurance holder to know your insurance benefits. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
- According to your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances.
- If our providers do not participate in your insurance plan or you have no insurance, payment in full is to be paid at the time of visit.
- **All current and prior patient balances including coinsurance and deductibles are due at time of service. Services will not be performed unless payment is collected.**
- An upfront service charge of $15.00 is required for filling out and processing any paperwork, including, but not limited to:
  - Disability
  - FMLA
  - Worker's Compensation
  - No Fault

  Forms will not be processed unless payment is received
- Medical record requests are charged 75 cents a page in accordance with New York State law.
- A charge of $25.00 for office visits/$50.00 for procedures and surgeries will be assessed for all no-show or canceled visits with less than 24 hour notification - **NO EXCEPTIONS**
- There is a $20.00 fee for all returned checks.
- Any changes in address, employment status, or phone number must be communicated to the staff at time of check in.
- **Patient responsibility balances over 120 days will be discharged from care.**

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 this 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 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
Parent/Guardian Signature if Patient is a Minor

Date

_____

Patient Date of Birth

_____ _____

Print Patient Name

Parent/Guardian Print Name and Relationship to Patient