ADVANCED WOMEN'S OBGYN ASSOCIATES **POLICIES AND CONSENT**

Name: _____ **Date _____**

As your physicians, we welcome you to our office and stand committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our office policies.

You will be asked at each visit to present the office with your insurance card and to notify us of any changes in name, address, phone number or insurance information. Because benefits on most managed care plans vary by employer, we recommend that you review your individual benefits and obtain necessary authorizations from your primary care physician prior to your visit.

We attempt to verify eligibility and benefits of each patient's insurance prior to her scheduled appointment. We are able to use the information initially provided by your insurance company to approximate your responsibility of payment based on your stated reason for the visit. Occasionally, we are given inaccurate information. In these cases, we will either send you a refund of the overpayment (usually within 6-10 weeks) or we will send a statement requesting the additional amount as determined by your insurance company's final disposition of the claim.

Annual "well-woman" exams are preventative visits and are not paid by all insurance carriers. For example, Medicare only pays for a Pap, pelvic and breast exam once every two years. You will be responsible for payment if any portion of the exam is not covered by your insurance.

Annual exams do not typically allow time to address all problems you may be having. If the physician determines that more time is needed to evaluate any additional concerns, we may need to schedule an additional office visit to complete the evaluation and treatment.

We are participating Medicare providers, and we will file Medicare claims for you. We request payment for the 20% of the allowable Medicare charges and any deductible

Unless arrangements have been made in advance, co-payments, co-insurance and any outstanding balances are expected at the time of service. There may be some services that are either not covered or limited in coverage. It is important to note that you are ultimately responsible for payment of your account. Any patient credits will be applied to other outstanding balances prior to any refund. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.

If, at any time, you feel our charges to be in error, you must notify our billing department immediately or upon receiving your first statement.

If you are not currently covered by a medical insurance policy, you will be responsible for paying the balance of your bill at the time of your visit. If you are unable to do so, please notify the office staff prior to your visit so that we may offer our payment options to you.

Whether or not you have medical insurance, emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

By signing below, you are accepting responsibility for any charges incurred in the collection of this account, should you default on payment. Such charges include, by are not limited to, legal fees, collections fees, or late charges. The fee applied to the collection of debt is 100% of the amount owed plus an additional fee of 35% of the debt. You are also agreeing to be responsible for an additional $35 charge for any check refused by your bank.

I acknowledge that I have read and understand the above policy and that I have been given an opportunity to voice my concerns. I also understand that I must notify the office immediately if I have any questions about my account.

I request and authorize healthcare services by my physician and his/her designees as may deem advisable. This may include preventative, diagnostic, imaging and laboratory procedures and medication administration.

I acknowledge that I have been given the Advanced Women's OBGYN Notice of Privacy Practices. These are also available on our website: advancedwomensOBGYN.com. I understand my responsibility to read this material. If I have questions or complaints, I should contact the Privacy Official. I acknowledge that Advanced Women's OBGYN will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

Patient initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Guardian) signature: _____ **Date: _____**