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NATALIA ALEJANDRO, M.D., F.A.C.O.G.
NELLY RIVERA, M.D.
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# GROUP FINANCIAL POLICY FOR GYNECOLOGY CARE

Thank you for choosing Advanced OB/GYN as your health care provider. We are committed to providing you with the best possible health. The following information is provided to ensure you are aware of and understand our financial policies.

Please ask if you have any question about our fees, policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

**Please initial each line below:**

_______ **Co-pays/Co-Insurance/Deductibles** - The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, deductibles are past due at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express for your convenience. If a patient is a minor (18 years and younger) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian is responsible for any payment due at the time of service. If you are unable to pay for necessary medical care, you may be eligible for a payment plan. It is your responsibility to inform us of your financial need prior your visit. Please ask to discuss arrangements with our billing department.

_______ **Insurance Claim** - We will submit medical claims to your insurance company. Any balance after processing of our claim by our carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. Although we may estimate what your insurance company may pay, it is the insurance company that make the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to those charges above the usual and customary allowance. If we are out of network, and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

_______ **Annual Exams** - These visits are intended to be preventative in nature and typically include age appropriate history, exams and counseling. These visits are not intended to be problem-focused. While we are happy to manage additional problems that exist at the time of an annual exam if possible, it may be appropriate to change the type of visit such that a co-payment would be required. This decision cannot be made until your visit has been completed and may depend upon the nature of the problem and the amount of time required to adequately address it.

_______ **Medicare Patients & Annual Wellness Visits** - Medicare has made changes to their coverage for annual wellness visits, specifically when they are performed at the gynecology office as opposed to your primary care provider. In general, your annual wellness visit should be performed by your primary care provider. If your wellness visit is performed by our office, charges will apply, and you may receive a bill. Please call the office upon receipt of any bill to see if a discount can be applied- many times that is available.

_______ **Self-pay Accounts** - Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

_______ **Assignment of Benefits** - I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to Advanced OB/GYN. I understand that I am responsible for any amount not covered by insurance.

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_______ **Cancellation of Appointments** - Advanced OB/GYN requires 24-hour notice of appointment cancellation. There is a fee of $25 for appointments that are missed and not previously cancelled.

_______**Returned Checks**- The charge for a returned check is $25 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_______**Outstanding Balance Policy**- All accounts (outstanding balances) ***must be paid*** in full prior to next appointment, unless prior payment agreement (s) are made in writing. In the event that a patient balance remains outstanding and no resolution can be made, my account may be sent to a collection agency and/or I may be discharged from the Practice.

_______**Laboratory Fees**- Most laboratory charges, such as blood work, PAP and pathology tests, ordered through our office are billed directly to your insurance by lab company. If you receive a statement from one of laboratories, we request that you contact them directly to resolve any billing questions.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand the above information and agree to comply with these financial policies.

Print Patient Name: ______________________________________ Date of Birth:_____________________

Patient Signature: ______________________________________ Today's Date: _____________________

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