OB/GYN ASSOCIATES OF WNY

3050 ORCHARD PARK ROAD
WEST SENECA, NY 14774

AUTHORIZATION, RELEASE AND FINANCIAL POLICY

INSURANCE—We participate with most insurance plans. If you are insured by a plan that we do not participate with, we will submit a claim directly to the insurance company as a courtesy to you. If the claim is not paid in full within 45 days, the balance will automatically be billed to you. I understand and authorize the insurance company to pay insurance benefits directly to OB/GYN Associates of WNY, which may otherwise be payable to me.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES—We require a copy of your insurance card and your co-pay at the time of service. Non-payment of a co-pay at the time of service will incur a $10 service fee. Deductible and co-insurance are due at the time of service (it is the patient's responsibility to be prepared to pay). All balances that have been applied to the patient deductible and/or co-insurance must be paid in full within 30 days of claims processing. For patients with high deductible insurance plans, all estimated Obstetrical and Surgical charges must be prepaid as follows: Obstetrical deductibles and co-insurance must be paid in full within 4 months of confirmation of pregnancy. Surgical deductibles must be paid in full 1 week in advance of surgery. It is your responsibility to know if your insurance requires a referral or authorization for services, and it should be obtained prior to your visit. If your insurance is not accepted by our practice at an in-network or out-of-network level, you are expected to pay for services at the time of your appointment.

NON-COVERED SERVICES—Please be aware that some, and perhaps all, of the services you may receive may not be covered by your insurance. These will be your responsibility. If the patient is a minor (under age 18), it is agreed that you accept financial liability regardless of ownership of insurance coverage.

PROOF OF INSURANCE—All patients are required to provide proof of current insurance, and failure to provide such proof could result in being billed for the services rendered.

CLAIMS SUBMISSION—We will submit your claims and assist you in any way we reasonably can to help you get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests immediately. We are not party to the contract you have between you and your insurance company.

CHANGE OF INSURANCE—You are responsible for notifying us promptly if your insurance changes so that we can bill the appropriate insurance carrier in a timely manner. If you fail to notify us of your insurance change, you are responsible for all charges incurred.

NON-PAYMENT—If your account is over 90 days, you will receive a letter allowing you one last opportunity to pay your bill in full within 10 days or be discharged from care at OB/GYN Associates of WNY for non-payment of your financial responsibility. We do not accept monthly payments on balances due. We accept VISA/Mastercard/Discover for your convenience. If the balance is unpaid, we may refer the account to a collection agency. A charge of up to $50.00 may be added to your account. Please be advised that **you are ultimately responsible for any charges with OB/GYN Associates of WNY**. Unpaid balances will be reported on your credit report.

CHECKS RETURNED FOR NON-SUFFICIENT FUNDS—If you attempt to pay your debt with a check that is returned for non-sufficient funds, we reserve the right to charge your bank fees of, at a minimum, $35.00 and only accept CASH or CREDIT CARD for all future payments.

MISSED APPOINTMENTS—Our policy is to charge $25.00 for missed appointments not canceled within 24 hours of your appointment time. A $100.00 charge will be assessed for failure to cancel scheduled surgery within 48 hours of the appointment time.

Our practice is committed to providing the very best treatment to our patients. Please let us know if you have any questions or concerns.

I have read and understand all of the above policies. I agree that, regardless of my insurance status, I am responsible for the balance on my account for any services rendered. Also, I authorize the release to my Insurance company Information, including diagnosis and the records of any treatment rendered for purposes of obtaining payment.

SIGNATURE

DATE: