Acct. # _____

PENFIELD OB/GYN OFFICE FINANCIAL POLICY

Penfield Office: 43 Willow Pond Way, Penfield, NY 14526 (P) 585-377-5420
Irondequoit Office: 1734 Ridge Road East, Rochester, NY 14622 (P) 585-388-7380
Farmington Office: 1520 Route 332, Farmington, NY 14425 (P) 585-398-2040

We value our relationship with our patients. This financial policy has been established to prevent misunderstandings.

1. It is your responsibility to keep the practice updated with your most current information (insurance, address, phone, etc.).

2. Any questions regarding benefit issues or physician participation status should be directed to your insurance company.

3. We require 24 hours prior notice to cancel an appointment. A **$50 charge** is applied to all unkept appointments.

4. Co-insurance and deductibles are due at check-in at the time of service. If payment is not made at the time of service an administrative fee from **$25 to $75** will be added to your account depending on the amount due. For your convenience, we accept cash, checks, credit, and debit cards.

5. We participate with many local and national insurance plans. However, it is the patient's responsibility to understand whether your insurance has limits on the doctors you can see or the services you receive. Insurance plans are negotiated between insurance companies and employers. Therefore, everyone's medical coverage will not be the same.

6. Returned checks will incur a **$25 returned check fee**. In the event of a second returned check, your privilege to pay by check on future visits will be terminated and you will be expected to pay with cash, credit or debit card.

7. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, the patient will be fully responsible for any cost, including, but not limited to attorney fees.

I authorize the release of any medical information necessary to process insurance claims and/or comply with my health plan audit requirements and I assign benefits (including Medicare) of such claims to this practice. I acknowledge responsibility for payment of fees for all services rendered regardless of any insurance coverage. I agree that in the case of non-payment that I will be responsible for any and all collection fees and/or attorney fees.

DATE_____SIGNATURE _____