WOMEN FOR WOMEN OB-GYN

2 ½ Dearfield Drive Suite 101
Greenwich, CT 06831

By signing this form, I am acknowledging that:

- It is my responsibility to provide complete and correct insurance/billing information including presentation of a current insurance card to Women for Women OBGYN. This also includes effective start and termination dates. I understand that failure to do so may result in denial of benefits from my insurance carrier. In this event, I understand that I shall be responsible for services rendered by Women for Women OBGYN.

- I am responsible for co-pays, deductible, and percentages required by my insurance plan.

- I will be billed for "After Hours" patient initiated telephone management of medication/refills in the amount of $40. I also understand that this is not covered by my insurance plan.

- I will be billed the amount of $10 for called in prescriptions during office hours. I also understand that this is not covered by my insurance plan.

- In the event that I am referred to a specialist, laboratory, radiology facility I will be responsible to make certain that they are covered by my insurance plan and I will provide them with referrals and complete insurance/billing information.

- A $50 fee imposed for missed appointments, no shows, or late (less than 24 hour) cancellations of office visits. This will not be covered by my insurance.

- For overdue balances greater than 30 days, 6% interest will be applied to the total balance due. If the bill is not paid within 3 months it will be forwarded to collections.

- Additional $20 for copay's not paid at the time of visit.

If you have any questions regarding the above policies, please feel free to discuss these with the office staff.

I acknowledge that I have received this letter

_____	_____	_____
Patient signature	Patient Name (print)	Date