

Patient Responsibility Description
(Please carefully review the information below)

This is an agreement between Azalea City Physicians for Women, PC (ACPFW) and the Patient/Guarantor names on this form.

In this agreement the words, you, your and yours mean the Guarantor. The word Guarantor refers to the responsible party. The word account means the account that has been established in your name to which charges are made and payments are credited. The words we, us, and our, refer to Azalea City Physicians for Women.

Insurance is a contract between you and your insurance company. In most cases we are not a party in this contract. We will bill your primary insurance company as a courtesy to you. However in order to do so we must be supplied proper insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire balance. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you will be responsible for the entire portion of the charges not covered. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward any payment to us immediately. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and the balance will be your responsibility.

You are required to have your insurance card at each visit. If you do not have your insurance card you will be considered a self-pay patient in which case you will be responsible for the charges for that day's service. You have thirty (30) days to notify us of your insurance at which time we will submit a claim. Once your insurance carrier has paid we will refund the credit amount so your account equals zero. Please keep in mind if you have a balance and/or if your insurance company states you are partially responsible for the claim (i.e. co-pay and/or deductible) we will apply the credit amount to that balance and refund you the difference.

Returned Checks: There is a \$30.00 fee on any returned check (NSF). Once you have written an NSF check, we will no longer be able to accept this form of payment from you. You may pay with money order, cash, Visa/MasterCard or Discover. Writing an NSF check is a felony and if not paid we will be forced to report you to the District Attorney's Office.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer your collection balance to lawyer, you agree to pay the legal fees plus all court costs.

Payments: Unless we approve other arrangements, the balance on your statement is due upon receipt. We may require personal financial information in order to make a determination regarding an extended payment arrangement. If payment is not received we reserve the right to refuse appointments on delinquent accounts.

OB Patients: Once it has been determined you are pregnant we will contact your insurance carrier so as to determine what your financial responsibility will be. You will receive a detailed payment plan via mail. Monthly installment payments will be expected through the 7th month at which time your portion will be paid in full.

Surgical Patients: Should it be deemed medically necessary for you to have surgery or if you elect to have surgery, we will contact your insurance company so as to determine what your responsibility will be. We expect your portion to be paid in full prior to surgery or payment arrangements are coordinated.

By signing below, you the patient and/or guarantor are full aware of your financial responsibilities and agree to the above terms. I further authorize the release of medical information necessary for the completion of insurance forms, processing of the claim and receipt of the payments. If I have insurance, I request payment be made ACPFW. I authorize payment directly ACPFW for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am fully responsible for all co-payments and any charges not paid by my insurance. I understand that insurance coverage is based on an agreement between me/my employer and my insurance company. ACPFW expects to be paid in full for all services rendered. In the event of payment default, I agree to pay all costs of collection, including court fees and reasonable attorney fees. A photocopy of this authorization will be considered as effective and valid as the original.

Patient Name

Date

Responsible Party

Date

Witness Name

Date