

FINGER LAKES WOMEN'S HEALTH, LLC

OBSTETRICS AND GYNECOLOGY

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ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL/SURGICAL BENEFITS TO: FINGER LAKES WOMEN'S HEALTH, LLC FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. AFTER 90 DAYS OF DELINQUENT BALANCE, I UNDERSTAND THAT MY ACCOUNT WILL BE REFERRED TO COLLECTIONS AND I AM RESPONSIBLE FOR ANY FEES INCURRED. I UNDERSTAND THAT AFTER 60 DAYS, IF MY SECONDARY INSURANCE HAS NOT PAID MY CLAIM I AM RESPONSIBLE FOR PAYMENT.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE FINGER LAKES WOMEN'S HEALTH, LLC TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING INSURANCE FORMS FOR FINANCIAL BENEFITS.

MEDICARE-MEDICAID

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS UPON REQUEST TO MY INSURANCE COMPANY. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO FINGER LAKES WOMEN'S HEALTH, LLC ON MY BEHALF. I UNDERSTAND THAT FLWH WILL BILL MY SECONDARY INSURANCE FOR ANY REMAINING BALANCE. HOWEVER, I UNDERSTAND THAT AFTER 60 DAYS OF NON-PAYMENT FROM MY SECONDARY INSURANCE, I AM RESPONSIBLE FOR THE BALANCE.

ADVANCE BENEFICIARY NOTICE: (FOR MEDICARE SCREENING TESTS)

I HAVE BEEN NOTIFIED BY MY PHYSICIAN/LABORATORY THAT MEDICARE MAY DENY PAYMENT FOR THE ITEM OR SERVICE IDENTIFIED SINCE IT MAY NOT MEET THE MEDICARE SCREENING GUIDELINES. I UNDERSTAND THAT I HAVE THE RIGHT TO DECIDE WHETHER TO RECEIVE THE ITEM OR SERVICE. I HAVE DECIDED TO RECEIVE THAT ITEM OR SERVICE. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

SIGNATURE

DATE

PRINTED NAME