

# FINGER LAKES WOMEN'S HEALTH, PLLC

## OBSTETRICS AND GYNECOLOGY

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### **Patient Payment and Responsibilities**

*I understand that I am responsible for any prior authorization or approval, if required by my insurance policy or managed care program. I am also responsible for checking with my insurance company and/or employer to obtain and complete any required forms.*

I am aware that any deductible and co-payment amounts, as well as any other non-covered charges, are my responsibility, and must be paid at time of service unless other wise indicated.

I understand that it is my responsibility as a patient to contact my insurance carrier for information regarding current participation guidelines. It is my responsibility as a patient to know what is covered by my insurance plan, and that I am relying purely on the information provided by the insurance company. I recognize that it is not the responsibility of my medical provider to know my personal coverage information and responsibilities.

***I have read, understand, and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductible are my responsibility for today's services. I authorize my insurance benefits be paid directly to Finger Lakes Women's Health, LLC.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

cc: patient chart