

About Care GYN Associates, P.L.L.C.

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Financial Policies

Thank you for choosing About Care GYN Associates, the office of Dr. Lillian M. DeCosimo for your gynecological care. The following information is to detail our financial policies. These policies go into effect at the time of your **first** visit with Dr. DeCosimo and remain in effect for all subsequent office visits.

SELF PAY PATIENTS

All fees for services rendered will be paid in full at the time of your your visit

CO -PAYMENTS

Co-payments will be collected at the time of your visit. If you do not have your co-payment at the time of service, your office visit will have to be rescheduled. For your convenience, we accept cash, MasterCard & Visa credit cards.

PLEASE NOTE: If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay the physician's full fee at the time of service. We will then bill your insurance when the necessary and acceptable information is received.

PARTICIPATING INSURANCE, CHARGES TO PATIENT AND FINANCE CHARGES

The physician's billing representative(s) will file your office visits and surgeries to your insurance. company.

We will complete all requirements to get your claims paid in a timely fashion. however, any claim(s)

not paid by your insurance by **30** days from the date of filing, will become **your responsibility**. If your

insurance pays the claim after you have paid, then you will be reimbursed any amount that is due to

you in a timely manner. It is **YOUR** responsibility to ensure that your insurance company upholds their

responsibility of prompt payment to the **physician. It is also your responsibility to check with**

your insurance to verify that the physician is a participating provider prior to services rendered to you.

As your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has

not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within **30** days of billing,

professional fees are due and payable in **full** from you. After **60** days an **18%** finance charge will be applied to any

unpaid balances. In case of default of payment, you will be responsible for attorney, collection, and court fees. We

report all delinquent accounts to all credit bureaus.

NO SHOW or MISSED APPOINTMENT FEE

You will be charged a **\$100.00** fee if you fail to **give** our office a **24** hour cancellation notice or fail to keep your appointment. If you do incur this fee and fail to pay it, you will be dismissed from the practice.

Please sign receipt and acknowledgement of these FINANCIAL POLICIES.

Patient Signature: _____ **Date:** _____
(Parent/Legal Guardian if patient is a minor)

Patient Name: _____
(Please print clearly)