



Advanced Women's Care Center, SC

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DISCLOSURE/AGREEMENT FOR ADVANCED WOMEN'S CARE CENTER

Date: _____

Patient's Name: _____

Reason for today's visit:

- Routine Preventive Exam (I have NO medical complaint, significant problem, or abnormality of which I am aware.)
- I have a problem/complaint that I wish evaluated by the provider. My chief complaint is:

- My Insurance plan covers Preventive Medical Services.
- My Insurance plan does not cover Preventive Medical Services.
- I do not know if my insurance plan covers Preventive Medical Services, but understand that I am responsible for any charges incurred which are not covered by my insurance plan.

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance refuses to pay, for whatever reason. This office will file a claim on my behalf, however, if my insurance company denies payment for any reason (e.g. non-covered services, does not pay for preventive medical visits, my failure to secure a referral from my primary care physician, if needed), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for these, or any other services provided to me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

I verify that my insurance company is still _____ (insurance company name.)
In the event that my insurer changes, it is my responsibility to inform you. If I fail to do so, I accept full responsibility for payment of any denied claims.

Patient Signature

Date

Witness