



ASSOCIATES
— FOR —
Women's Medicine

PATIENT OBSTETRICAL FINANCIAL AGREEMENT

Patient Name: _____ DOB: ____/____/____ EDD: ____/____/____

This agreement is to inform you of anticipated fees, which may be acquired during the course of your pregnancy. We will call and review your obstetrical benefits with your insurance carrier after your first visit once we confirm your pregnancy. Our benefit specialist will call you to review your benefits and anticipated costs. AWM does require any estimated patient responsibility for the delivery to be paid by your 36th week of pregnancy.

Our billing department will contact you to set up a payment plan based on your insurance benefits. The estimated delivery balance must be PAID IN FULL on or before your 36th week of pregnancy.

If you have a HSA/HRA that you are planning to use to cover your estimated patient responsibility, you will need to fax or upload to the patient portal a letter confirming that information and show the amount is available. The benefit specialist can review this with you during your call.

During your pregnancy, providers may order labs, ultrasounds, or non-stress tests. These services will be billed to your insurance in addition to your prenatal visit and are not included in the provider's office visit. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. Your responsibility for these services will be determined by your contract with your insurance company.

Labs may be performed and billed by AWM. Additionally, labs may be sent to an outside reference lab. Those labs will bill you directly when processed outside AWM.

Should you have a change in insurance coverage, it is your responsibility to notify us immediately. Any delays could result in additional out-of-pocket expenses or denied claims.

Any unpaid or remaining balances on the patient's account after your insurance has made payment may be considered for collection and/or discharge if not paid promptly upon receiving a statement.

Our office accepts Check, Bank Card, Visa, MasterCard and Discover.

PLEASE NOTE THIS IS FOR PHYSICIAN SERVICES ONLY.
FACILITY SERVICES ARE BILLED SEPARATELY BY ST JOSEPH'S HOSPITAL (315) 448-5155.

Patient Signature _____

Date _____

A refund will be issued to you if your insurance company pays more than was originally estimated.

Estimates given by your insurance company are not a guarantee of payment. Any difference between quoted amounts and amounts actually owed will be the responsibility of the patient.

**If you have any questions, you can submit a billing question on the patient portal.
or contact our AWM Billing Office at 315.423.9722 AWM Billing Fax 315.423.9687**