Patient:_______________________________

This is an agreement between **Dr. Patrick S. Anderson M.D., Center for Gynecologic Oncology & Women's Health,** Creditor, and the patient/debtor named on this form.

In this agreement the words "you," 'yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payment credited. The words "we," "us," refers to Dr. Patrick S. Anderson M.D. Center for Gynecological Oncology and Women's Health.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payment and credit applied to your account during the month.

Payment options if you have no insurance:

A. You may choose to pay by cash, checks or credit card on the day the treatment is rendered. We accept MasterCard Visa, American Express, Discover, Debit, Checks & Money Order.

Payment Options if you have insurance:

A. Will bill your insurance company first then balance bill you if necessary. However, you must pay your co-pay at the time of your visit.
B. Your deductible and any out-of-pocket portions are due at the time services are rendered by cash, checks, or credit card.
C. If you choose to pay for all your treatment, we will request your insurance carrier to send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when statement is issued, and is past due if not paid within (30) days.

Charges to account: We have the right to cancel your privilege to make payment by credit card or checks at any time. If we elect to do so, further visits would then need to be paid in cash or money order.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to such contract. We will bill your insurance company as courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and the amount it pays. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment or non-payment from your insurance company.

Required payment: Any co-pay required by your insurance company must be paid at the time of service. This is an insurance requirement.

Return checks: There is a $25 fee for any checks returned by your bank.

Missed appointment: There will be charge of $25 for patients, who do not show for an appointment or cancel less than 24 hours prior to their visit, a $50 charge for new patients. This must be paid before your next appointment is scheduled. New patients with two (2) missed or cancelled appointments will not be accommodated. Established patients who miss or cancel three (3) consecutive appointments will be asked to transfer their records to another physician.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection cost which is incurred. If we have to refer collections to an attorney, you agree to pay all attorneys' fees, which we incur, plus all court costs.

Waiver of confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated for personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill attorney for charges incurred due to your personal injury case.

Co-signature: If this or another Financial Policy is signed by a person, other than the patient, that person is responsible until canceled in writing. If written cancellation is received, and accepted by us in writing it becomes effective with any subsequent charges.

Effective Date: Once you have signed the attached agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Transferring records: You will need to request in writing, and pre pay copying charge of $1.00 per page if you want to have your records sent to another doctor. You are authorizing us to include all relevant information, including your payment history. If you are requesting your record to be transferred from another doctor or organization to us, you authorized us to receive all relevant information, including your payment history.

120 Irvington Avenue
South Orange, NJ 07079

Phone: 973 762-7270
Fax: 973 762-1980

Center for Gynecologic Oncology
& Women's Health

Patrick S. Anderson, M.D.

Financial Policy