

Axia Women's Health

Patient's Name: _____

DOB: _____

**Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility**

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Patient Financial Responsibilities

- ✦ I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- ✦ You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- ✦ I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. Patient Responsibility and Benefit information provided by Axia Women's Health are based on information provided by your insurer at the time of service. Axia is not responsible for the accuracy of this information. **ACTUAL AMOUNT DUE TO AXIA WILL BE PROVIDED ONCE CLAIM IS ADJUDICATED BY PAYER.**
- ✦ I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
 - ⊆ Charge for returned checks.
 - ⊆ Charge for the copying and distribution of patient medical records.
 - ⊆ Charge for forms completion.
 - ⊆ Charge for missed appointments.

Patient Authorizations

- ✦ By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third-party payers required for payment of rendered health services.
- ✦ By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian Date