

**Patient Agreement & Practice Policy**

**Financial Responsibility**

I have requested medical services from Boston Pelvic Health & Wellness and understand by making this request, I become fully financial responsible for any and all charges incurred in the course of the treatment authorized. I authorize Medicare or any third-Party insurance to make payment directly to Boston Pelvic Health & Wellness for services rendered to me. It is my responsibility to obtain a referral from my PCP for specialty services if required by insurance. My signature below indicates that if I receive specialty care without a referral from my PCP, I will be financially responsible for such services.

**Co-Payments, Deductibles and Past Due Accounts**

Co-Payments, deductibles and past due balances are due at time of medical services. If you don’t pay your co-pay at the time of your visit you will be billed. We will make multiple attempts to settle any outstanding balance before referring your account to collections. We accept Credit card, Checks, and Cash.

**Cancellation and No-Show Policy**

Please be advised that we have a 24-hour cancellation policy. We understand that there are times when you must miss an appointment due to emergencies or obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving treatment. After your first missed appointment we charge a $35.00 fee. If you are scheduled for Testing or procedure in the office and you miss your appointment without a cancellation call, we charge a $50.00 fee.

**Consent to Use and Disclosure of Information for Treatment, Payment or operations.**

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that information in my medical records may be used and disclosed to persons other than Boston Pelvic Health & Wellness to carry out their responsibilities in connection with my medical treatment, in payment for health care services rendered to me and in activities related to health care operations. I acknowledge that I have been provided the Boston Pelvic Health & Wellness Notice of Privacy Practices. If you have any questions regarding your account, please contact our office. My signature below acknowledges that I have read this policy, understand and agree to consent for treatment and my financial responsibility.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s or Legally Authorized Representative)