CNY Women's Healthcare
Providing Compassionate Care for Women In Every Phase of Life.

5000 Brittonfield Parkway* Suite A 128
East Syracuse, NY 13057
(315) 446-4400 phone * (315) 446-4201 fax

By **initialing below**, I am indicating that I have been given an opportunity to read the policies, relevant to me, set forth by CNY Women's Healthcare. I understand that I may, at any time, request a copy of any or all of these policies.

_____ Blood Transfusions (signature required on 2nd page)

_____ CNY Women's Healthcare Providers

_____ Medical Information Release/ Assignment of Benefits

_____ Notice of Privacy Practices (HIPAA Policy)

_____ Notice of Patient Bill of Rights

By signing this form, I acknowledge that I have been advised of all applicable policies.

_____ _____

Patient Signature **Date**

_____

Patient Name (printed) and Date of Birth

_____ _____

Office Staff Witness Signature **Date**

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Blood Transfusions

Obstetrics and Gynecology is a medical specialty where patients can experience sudden and severe hemorrhage. This loss of blood can be very large and in these situations a blood transfusion can be lifesaving.

It is never the policy of the physicians at CNY Women's Healthcare to administer blood transfusions unless absolutely necessary. Also, except in extreme emergencies, the reason for a transfusion would certainly be explained to the patient beforehand. ***However, the physicians in this office could never agree to care for a patient who would refuse a blood transfusion under any circumstances (Religious belief included).*** To not allow a blood transfusion removes a valuable method of treatment and places the physician in the unacceptable ethical position of possibly having a patient die from hemorrhage whose life could have been saved by blood transfusion.

Therefore, before you can be seen as a patient at our office, we request that you initial and sign the form given to you at check in and sign this form indicating that blood transfusions are an acceptable form of treatment (copy of this policy is also in the binder given to you at check in).

_____ _____

Signature of Patient and Date of Birth Date

_____ _____

Please Print Name Office Staff Witness Initials

** A copy of this form is available upon request, please ask a receptionist **

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to CNY Women's Healthcare. When you schedule an appointment with CNY Women's Healthcare, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and **no later than 24 hours prior** to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our **Appointment Cancellation/No Show Policy** below:

- Any **established patient** who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show or cancel/reschedule an appointment with no 24-hour notice a second time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be **dismissed** from CNY Women's Healthcare.
- A **72-hour** notice is required for **any surgery/procedure cancellation**, or a $100 cancellation fee will be charged to your account.
- Any **new patient** who fails to show for their initial visit will be charged a No-Show fee of $50.00. This must be paid prior to making another appointment. If a new patient No Shows a new patient appointment for the **second time** their visit will not be rescheduled.
- The fee is charged to the patient. **These fees are considered Non-Covered services by ALL insurance carriers and are due and payable by you.** The fee is due at the time of the patient's next office visit.
- As a **courtesy**, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office. You may contact CNY Women's Healthcare at the number below Monday through Friday 8am to 4:30pm.

CNY WOMEN'S HEALTHCARE (315) 446-4400
5000 Brittonfield Parkway, Ste A128 East Syracuse, NY 13057

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____
Signature Relationship to Patient

_____ _____
Printed Name Date

CNY Women's Healthcare
5000 Brittonfield Parkway * Building A, Suite 128
East Syracuse, NY 13057
Phone (315) 446-4400 * Fax (315) 446-4201

Patient Demographics

Last Name _____ First Name _____ Middle Int. _____
Social Security # _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____

Email Address _____

Primary Care Physician _____ Phone # _____

Pharmacy Name _____ Phone # _____

RELEASE OF INFORMATION TO Relative / Friend

The following named person(s) may have access to all checked information (please checkmark below all that apply) from CNY Women's Healthcare regarding my care (I understand that I may add or remove names from list at any time)

☐ **MEDICAL** ☐ **BILLING** ☐ **APPOINTMENT INFORMATION** ☐ **EMERGENCY BASIS**

**** I do not wish any of my information to be shared with anyone at this time*** _____ **(please initial)**

Name _____ Relationship _____
DOB _____ Ph # _____

Name _____ Relationship _____
DOB _____ Ph # _____

Name _____ Relationship _____
DOB _____ Ph # _____

Name _____ Relationship _____
DOB _____ Ph # _____

** I give permission to CNY Women's Healthcare to send appointment information to my email above* _____ **(please initial)**

_____ _____
Patient name (printed) date

_____ _____
Patient signature office staff witness (initials and date)

CNY Women's Healthcare

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_____ _____

Patient Name ***Date of Birth***

Financial Policy (revised 6/2023)

The providers at CNY Women's Healthcare are here to serve your healthcare needs and are dedicated to providing you the best care possible. The intent of this policy is to clarify the role of the patient and the provider regarding billing issues. We ask that you ***CAREFULLY*** read and initial after reading each policy regardless if applicable.

- ***RELATIONSHIP:***

  Our relationship is with you, the patient, not your insurance company. Care will be administrated to you based on medical necessity, not according to what is covered under your health insurance policy. Because there are numerous insurance companies that have many product lines, it is the patient's responsibility to know the benefits/coverage and requirements of their health insurance plan. Any questions regarding coverage and/or payments of claims should be addressed directly to your insurance company. This can be an overwhelming process so at any time you need help, we would be glad to assist you but ultimately it is your responsibility.

  Int _____

- ***INSURANCE CHANGES:***

  It is your responsibility to inform staff of any and all insurance changes. You will be expected to present your current insurance information at ***each*** visit. If you have changed insurances you ***must*** provide a copy of your new card. ***If you have lost coverage you will need to notify staff immediately. Failure to disclose this information will be reason to be discharged from the practice.***

  Int _____

- ***LOSS OF INSURANCE COVERAGE:***

  In the event that you lose your insurance, you must notify the billing office immediately. Our office does NOT participate with *Medicaid.* In the event you lose your insurance you will be responsible to pay out of pocket at time services are rendered and for any fees that are incurred the day of your visit. After that you will need to either transfer care or seek a *Medicaid HMO* that we accept. Our obstetrical patients will pay for delivery fees ahead of time. In the event that you cannot pay out of pocket for services rendered at the time of service, you will need to transfer your healthcare to another practice.

  Int _____

Office Staff Witness _____

Patient Name: **_____ Chart# _____**

- ***WE DO NOT PARTICIPATE WITH OR ACCEPT MEDICAID OR PCAP.*** However, we do participate with the following Medicaid Managed Care Plans:
  - ***Fidelis***
  - ***Molina***
  - ***United Healthcare Community Plan***

If you have Medicaid as a secondary insurance, you will be responsible for any balance not covered by your primary insurance company.

Int _____

- ***PATIENTS WHO LOSE THEIR INSURANCE WILL BE GIVEN 30 DAYS TO OBTAIN NEW COVERAGE UNDER A NEW PLAN WITH WHICH THE PRACTICE PARTICIPATES AND ACCEPTS.*** Failure to do so may result in the patient being discharged from the practice. The patient will be responsible for any charges or fees incurred until the new coverage becomes effective. **Payment will be due at the time service is rendered.**

Int _____

- ***METHODS OF PAYMENTS:***

The practice accepts Cash, Checks, and Credit Cards for your convenience. **There will be a $35.00 returned check fee for any returned checks.**

Int _____

- ***COPAYS, COINSURANCE AND DEDUCTIBLES:***

According to your insurance plan, YOU are responsible for ANY and ALL copayments, co-insurances and deductibles. All current and prior patient balances including coinsurance and deductibles are due at the time of service. Service will not be performed unless is received.

Int _____

- ***LATE ARRIVAL POLICY:***

A late arrival is defined when a **patient arrives more than 15 minutes late**. Arriving late will cause the patient to be **rescheduled** at a later time and date to accommodate other patients on the schedule who arrived on time. Repeat offenders may be discharged from care.

Int _____

- ***STATEMENT FEE:***

A $10.00 statement fee will be charged to your account in the event that you do not pay your co-pay at the time of your visit.

Int _____

Office Staff Witness_____

Patient Name: _____ **Chart#** _____

- ***CHARGES INCURRED OUTSIDE OF OUR OFFICE:***

If your visit includes lab tests, anesthesia, biopsies, pap smears or cultures you will receive separate billing from the company performing the processing and evaluation of those tests. It may take as long as 4 weeks to receive those bills. If you receive medical care during a hospital inpatient or outpatient encounter, you may receive separate bills from the hospital, the anesthesia department and other healthcare providers involved in your care. Any questions related to these bills cannot be answered by this office and will need to be directed to the billing entity***. If you need to have your labs sent to a specific laboratory please notify our office before a test is performed.***

Int _____

- ***FORMS:***

There is a $15.00 administration fee that is required for filing out and processing any paperwork, including but not limited to: ***Disability, Workers Compensation, FMLA, and No Fault.***

Int _____

- ***WELL WOMAN (Preventative) AND PROBLEM FOCUSED EXAMS:***

A Well Woman exam is when a healthy patient is seen to screen for various illness and diseases: This is considered preventative medicine. A problem visit is one where the patient has a specific concern, symptom, or complaint. We are required to submit claims based on the services you receive. If we provide both, Well Woman and a Problem Focused Exam then both services may be billed to your insurance company. Depending on your insurance coverage, some or all of the cost may have to be billed to the patient. We recommend you contact your insurance carrier prior to each visit and inquire about the type of benefits you have. Once a claim has been submitted to your insurance carrier, the office will not change the coding in order to circumvent an insurance denial as this may be considered insurance fraud.

Int _____

- ***SURGERIES:***

As a courtesy to our patients, we check the surgical benefit with your insurance company prior to the procedure being performed in our office or at the hospital. Again this is a courtesy and we advise you to check your insurance coverage/benefits as well. We will also check the anesthesia benefits for an in office procedure just to give you an estimate of how much you will owe for the anesthesia portion of the procedure. Anesthesia is supplied by CNY Anesthesia; they will bill your insurance company separately for their services. CNY Women's Healthcare is ultimately NOT responsible for any hospital, surgical or anesthesia charges. It is up to the patient to know their insurance policy and benefits.

Int _____

- ***PATIENT PAYMENTS:***

All in-office surgeries/procedures will be pre-certified prior to the date of service. Benefits will be quoted by the insurance company based on your contract. Your co-insurance and/or deductible are REQUIRED to be paid in FULL the day of the procedure. Failure to pay your financial portion of your bill will result in your surgery/procedure to be postponed and/or rescheduled until paid in full.

Int _____

Office Staff Witness _____

Patient Name: _____ Chart# _____

❖ ***BAD DEBT POLICIES***

❖ ***DELINQUENT ACCOUNTS:***

Accounts that are delinquent for more than 60 days and have not been assigned payment arrangements with the practice are subject to interest charges of 1.3% per month.

Int _____

❖ ***PATIENT BALANCES OVER 120 DAYS:***

Patient's, who do not make reasonable progress toward paying outstanding obligations to the practice may at the sole discretion of the physician, be discharged from the practice. If a patient has been discharged from the practice they will be given thirty (30) days notice at which time they may request emergent medical services only. Patients will still be financially responsible for their account balances. Patients with a balance over 120 days will be sent to a **Collection** Agency and will be reported to the three (3) National Credit Bureaus. All accounts sent to collections will have a 20% collection fee charged to their account balances. Patients will be responsible for all attorney and collection fees the practice may encounter in collecting their outstanding balance.

Int _____

I, _____, have read this four (4) page document and understand my financial obligations to CNY Women's Healthcare. I agree to all the terms and conditions.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Guarantor Name: _____ Date: _____

Guarantor Signature: _____

Relationship to Patient: _____

Office Staff Witness _____