

ADVANCE BENEFICIARY NOTICE – PATIENT RESPONSIBILITY

I understand that it is my responsibility to verify that the physician I am seeing at Carol L. Egner, M.D. & Associates, Inc., (DBA, Women Partners in OB GYN) is a participating physician with my insurance company and/or managed care network. I understand that I will be responsible for payment in full for any services my insurance company denies payment for, due to non-participation of the physician providing services for Carol L. Egner, M.D. & Associates, Inc.

I understand that I am financially responsible for all services including those not covered under the provision of my insurance policy contract. I acknowledge that my insurance company may not cover annual examinations or routine preventive health care services; therefore I will be fully responsible for any balance due in full if payment is not received.

I understand that I am financially responsible for payment in full at the time of service if I am a self pay patient.

Patient Name (Printed)

Patient Signature

Date