Laura Korman, MD, Michelle Sang, MD
Sheryl Horwitz, WHNP, Sangita Ghimire, WHNP

FINANCIAL POLICY: Synergy Women's Health Care values the confidence you have shown in choosing us as your healthcare provider. As a courtesy, we will bill your insurance carrier on your behalf. You are ultimately responsible for payment of your bill, including deductibles, co-payment/co-insurance and non-covered services as determined by your insurance carrier. Insurance cards must be presented and co-pays will be collected at the time of service. Synergy will require payment in full for in-office procedures and surgeries at the time of service (or at a pre-operative appointment). Any remaining balance owed by you, after insurance has paid, is due in full when you receive your first statement.. A fee will be charged for non-sufficient funds checks. Balances not paid within 30 days may be subject to additional collection fees. Separate billings may be received for laboratory, anesthesiology, radiology, hospital services and "on-call" or surgical assistant providers who are involved in your care and are subject to their financial policies.

SELF PAY PATIENTS: Synergy Women's Health Care patients without insurance are required to pay in full at the time of service. Self-pay patients are offered a 20% discount on all office visits.

CANCELLATION POLICY: As a courtesy to our physicians, we request 24 hours notice for any office appointment you will not be able to keep. Patients scheduled for surgical procedures in the office or hospital are required to give two-weeks notice for any non-emergent cancellation or reschedule. Failure to provide timely notice, or neglecting to show up for your scheduled appointment(s), may result in a cancellation fee and/or termination from the practice.

- **NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT AND CONSENT**: We are required by law to maintain the privacy and security of your protected health information. We have met many conditions in the law before we can share your information. We typically use or share your health information in the following ways:**1** . We can use your health information with other professionals who are treating you. **2**. We can use and share your health information to run our practice, improve your care and the publics' health. **3**. We can use and share your health information to bill and get payment from health plans or other entities. **4**. We will not share your information other than as described here unless you give us permission in writing.
  By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

BENEFIT ASSIGNMENT: I, and/or my dependent(s), assign directly to This Practice all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This Practice may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will continue indefinitely unless revoked by me in writing.

PATIENT/ PATIENT REPRESENTATIVE SIGNATURE By signing below, I acknowledge that I have read and understand all information included in this policy and allow this Practice to download any historical pharmaceutical history.

_____ _____ _____
Patient/Patient Representative Signature Relationship (if not patient) Date