

My Friend's Gynecologist, LLC ~ Dr. Terri Vanderlinde

Suite One 839 Central Ave. Dover, NH 03820 603-516-0000

TERMS OF SERVICE

ALL FEES ARE PAID ON OR BEFORE THE DATE OF SERVICE

(unless other arrangements are made PRIOR to the visit.)

_____ Our goal is to help you with your Gynecological Wellness and Health Maintenance, through conventional Medicine and Surgery and/or Holistic Alternatives. I will provide with you the most accurate and all-encompassing advice that I can, to help you make your own best decision in your health care. Some of the options will be covered by your insurance plan, some won't.

_____ We accept all patients in this practice, regardless of their type of Health Insurance coverage or lack thereof. Sometimes we are a "Participating Provider" in your plan's network; sometimes we are considered "Out of Network". Please make sure that you inquire about our billing practices in regard to your specific plan.

_____ Most insurances cover most Routine and Problem Gynecological visits. Sometimes they may require a referral from your Primary Care Doctor. It is **your responsibility** to obtain a referral, if needed. It is **your responsibility** to provide us with detailed information regarding your particular insurance contract (*e.g.* if there is a high deductible, if **only routine** or **only problem** visits, labs and x-rays are covered, etc.) We will **not** re-bill any properly coded insurance forms.

_____ If you have no insurance, please do not let that be a deterrent to keeping yourself well. We will work with you to set up a payment plan in advance of your appointment. At least **half** of the cost of the visit or surgery is expected **on or before** the date of service. The balance can be paid, interest free, over the next 2 months.

_____ Please initial each paragraph that you have read. By signing below, you are testifying that you have thoroughly read and understand each of the above points. You are also swearing that you, alone, will be responsible for any uncovered service, supplies or outstanding balance.

Signature Patient/Guardian _____ Date _____

Printed Name _____ Witness _____