A New Life

OB/GYN of Broward

Experience Compassionate Care.

Jane E. Matos-Fraebel, M.D., F.A.C.O.G.

YEARLY WELL WOMAN EXAMS / ANNUAL WELLNESS VISITS

By this letter and signature, I acknowledge that my primary insurance company is

_____

I have informed Dr. Matos that this is my ***only*** coverage. If I fail to disclose that I have other insurance coverage, I may be responsible for my bill in full.

As a rule, insurances companies allow for only one annual wellness visit yearly. Most insurance companies require that this visit takes place one year and one day from the last annual wellness visit.

If you have scheduled an annual wellness visit please understand that an annual wellness visit assumes that you do not have any significant complaints. If you have complaints that you would like us to address, we will do our best to accommodate you if our schedule permits. A co-pay or co-insurance may apply in these cases. In rare instances, you may be asked to return to the office to complete your visit.

By this letter and signature, I also certify that I have not used my annual wellness visit for this calendar year. If I fail to disclose that I have already used my annual wellness visit earlier this year either at this office or at another physician's office, I will be responsible for my bill in full.

Please note: Although most there is usually no charge for an annual wellness visit, you are responsible to pay your specialist co-pay, coinsurance, any past due balances and/or any unmet deductible amounts *at the time of service* should any charges apply.

We are happy to file your insurance claims for you, but the balance is your responsibility if your insurance company or plan does not pay after 30 days. Any amount not covered by your insurance policy is due immediately after you receive your first invoice from us.

To our Medicare Patients: We will bill your secondary insurance provider directly. You will be asked to sign an Advanced Beneficiary Notice for service not covered under Medicare.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____