

INSURANCE AND CREDIT AGREEMENT

1. I certify that the information I have reported with regard to insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier, or in the case of Medicare Part B Benefits, to the Social Security Administration and Health Care Financing Administration.
2. I hereby authorize Preventive Women's Health to apply for benefits on my behalf for covered services rendered and I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Preventive Women's Health, for services rendered.
3. A copy of this authorization may be used in place of the original. Either my insurance carrier or I may revoke this authorization in writing at any time.
4. I understand and agree that I am financially responsible for charges that I incur whether or not my insurance company pays them.
5. I hereby request that Preventive Women's Health extend credit for medical services provided now and at any time in the future when I do not pay for the services on the day that they are rendered. I agree to pay a Returned Check Fee of \$50.00 per returned check whenever my bank upon first deposit does not honor my check.
6. I represent that I have sufficient assets legally available to Preventive Women's Health, for the payment of the total balance due, plus the value of any additional services authorized. I understand that I am responsible for payment of the full medical fee, regardless of any insurance coverage, which may be applied. I agree to make payments of the balance due, and if not so paid, to pay all cost of collecting it, including attorney's fee of 40% of all amounts due and court costs.

I have read, understand, and agree to all of the foregoing terms.

Signature of Patient or Guardian

Date

Please list any persons you would like to authorize to have access to your billing, appointment, or health information (such as your spouse, caregiver or family member).

NAME

RELATIONSHIP

Signature of Patient/Legal Guardian

Date