Progressive
WOMEN'S CARE

CONSENT FOR CARE AND TREATMENT

Patient Name (Please Print) _____

I, the undersigned, do hereby agree and give my consent for Progressive Women's Care to furnish medical care and treatment to _____, considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

_____ _____
Patient/Guardian Signature *Date*

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed to us, you recognize an obligation to promptly remit same payment to Progressive Women's Care. This does not apply for those patients that are on an HMO plan or considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

When you pay by check, you expressly authorize the physicians of Progressive Women's Care, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales taxes). Please note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not mean, however, that Progressive Women's Care cannot collect a return check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read an explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____
Signature: Patient/Guardian/ Responsible Party *Date*

_____ _____
Practice Representative *Date*

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name (Please Print) _____

I, the undersigned, do hereby confirm that I have been give access to and have reviewed a copy of Progressive Women's Care Notice of Privacy Practices. *I would like a copy of this statement.*

_____ _____
Signature of Patient/ Guardian *Date*