NORTHWEST WOMEN'S CLINIC

Financial Responsibility: I understand that Northwest Women's Clinic will bill my insurance company as a courtesy, but I am ultimately responsible for all charges. I agree to pay all balances not covered by insurance. If my insurance plan requires a referral, I understand it is my responsibility to obtain one and I agree to be responsible for any penalty assessed by my insurance for failure to obtain a referral. I understand my doctor recommends treatment based upon my individual health needs and has no foreknowledge of whether a recommended treatment will be covered by insurance. I understand that to protect myself from unnecessary personal financial obligations, I must review my benefits with my insurance company prior to receiving treatment.

I have read and understand the above information _____(Initials)

Assignment of Benefits: I hereby assign and transfer to Northwest Women's Clinic all medical provider benefits payable for services rendered to me by NWWC. I authorize and direct the insurance company to pay all such benefits to NWWC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and NWWC.

I have read and understand the above assignment _____(Initials)

Consent to Release Claims Information: I hereby consent for Northwest Women's Clinic, their employees and agents, to release and disclose all information concerning my medical care and treatment to all appropriate persons for the purpose of treatment, health care operations and evaluating claims for payment or reimbursement. I hereby authorize Northwest Women's Clinic, its employees and agents to act on my behalf in completing claims. I may revoke this consent in writing at any time and all future disclosures will then cease.

I have read and understand the above release _____(Initials)

I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

_____
Patient's Printed Name

_____
Signature Date

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is described as follows:

_____
Signature of Authorized Representative Date Relationship to Patient