DOWNTOWN WOMEN
OB-GYN ASSOCIATES, LLP

Date_____

To All Patients of Downtown Women Ob-Gyn:

We appreciate and respect the trust you place in us to provide you with gynecologic and/or obstetric care and services.

Please understand that your benefit plan is an arrangement that involves you, your insurance carrier and your employer. Occasionally, gynecologic, pre-natal, and delivery care that you request from us is not covered by your plan or there is a deductible, co-payment, or co-insurance that you or we are not aware of at the time of your visit.

In order for our office to run smoothly and continue to offer you high quality care, we respectfully request that you sign below to authorize Downtown Women Ob-Gyn to keep your signature on file and charge your credit card for the balance of charges not paid or covered by insurance.
You will receive a courtesy call prior to our charging in excess of $250.00.

Thank you for your cooperation,

Downtown Women OB-GYN Associates, LLP

Name: _____ Entity ID #_____
Please Print Clearly

Name on Credit Card / Flex Card: _____

Card type: (please circle one):
Visa
MasterCard
American Express
Discover:

Please indicate both numbers.

Credit Card Number: _____

Expiration Date: _____
Security Code (3 digit code on back of card)_____
Billing Zip Code_____

Flex Spending Card Number: _____

Expiration Date: _____
Security Code (3 digit code on back of card)_____

Signature: _____
(Patient)
Date: _____

Please note: Scheduled appointments not canceled by 5PM the prior business day are subject to a $40.00 no show fee. Returned checks are subjected to a $10.00 returned check fee.

09/22/2011

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