

**COPAYS ARE DUE AT THE TIME OF SERVICE.**

**WE DO NOT ACCEPT PUBLIC AID AS AN INSURANCE.**

**AUTHORIZATION FOR SERVICES:**

I authorize this medical practice to provide reasonable and proper medical care, and it is my responsibility to assure that complete referral and pre-certification documents are provided or sent to this practice in a timely manner. I authorize insurance benefits to be paid directly to **Woman to Woman, P.C.** I also authorize release by them of any records, documents, or other information required of them by other parties. I understand insurance claims will be filed based upon the information indicated above and that I am responsible for any amounts not paid by insurance within 90 days. I understand that if I have Public Aid as a secondary insurance, I will be responsible for my copay and any balance not covered by my primary insurance. I further understand and agree to the responsibility to pay in full, and that if collection and/or legal services are required, the amount outstanding and all other reasonable fees and costs incurred in conjunction with the collection are due upon demand.

Signature \_\_\_\_\_ Date \_\_\_\_\_