Consent for Treatment – I consent to and authorize necessary medical treatment, exams, labs, injections/drugs, performance of operations, conduction of X-ray, hospital services or other studies that may be used by the attending physician, nurse or staff.

Authorization for Release of Information – I authorize the physicians of Complete Women's Care of Alabama PC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.

Assignment of Benefits – I hereby authorize payment directly to Complete Women's Care of Alabama PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but do not exceed the charges for these services. I understand that I am financially responsible for any charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

Medicare – If my insurance is Medicare; I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct. I certify that I am the patient or am duly authorized by the patient's general agent to execute this document and accept its terms.

Guarantee of Account – For services furnished by Complete Women's Care of Alabama PC I hereby authorize the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama.

No Show Fee – We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide a 24 hour notice. Appointments which are not cancelled may be subject to a $50.00 fee, per occurrence, that is not covered by insurance.

Financial Agreement – I fully understand that I am ultimately responsible for any and all of the charges associated with my account. I understand that I will be responsible for any and all charges incurred in the collection of any balance due including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline or text number I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communication. It is understood that failure to pay for services rendered may result in a dismissal from this practice.

Patient Signature_____ **Date**_____

Responsible Party Signature_____ **Date**_____