RESPONSIBILITY FOR PAYMENT

I agree to be responsible for the fees owed to The Woman's Health Pavilion ["the practice"] for services rendered to me should my insurance company deny payment for any reason whatsoever. I further agree to be responsible for all co-pays, deductibles, co-insurance and other amounts not covered by my insurance. If I do not have insurance or if my insurance is not effective on the date of service, I agree to be responsible for the fees for the services provided.

I agree to notify the practice immediately of any changes in my insurance. I acknowledge that a failure to do so may result in a denial of coverage for a variety of reasons including but not limited to inability of the practice to obtain pre-certification or pre-authorization of benefits. In such event, I shall be responsible for fees for denied services.

***I acknowledge that each insurance carrier offers a multitude of specific plans; as such, it is not possible for the practice to determine exactly what coverages my plan allows. I acknowledge that as a covered subscriber, it is my responsibility to determine allowed coverage, and to understand deductibles and co-pays which may apply for services rendered by the practice*.**

_____Initial

I further agree to provide the practice with a valid credit card for any payments due.

In the event I do not pay the fees including but not limited to co-pays, deductibles, co-insurance or out of pocket expenses, or if my insurance does not cover all of the fees for the services provided by the practice, I agree to be responsible for collection costs incurred by the practice, including legal fees at the minimum rate of 40% of the principal amount due, court fees, filing fees, and interest thereon from the date of service through the date of payment at the greater of 16% per annum or the maximum amount permissible by law. I understand that unpaid charges over 60 days past due may be forwarded to a collection agency and/or attorney for further collection efforts at the practice's discretion.

_____Initial

I authorize, release and consent to the use by **THE PRACTICE** of my protected health information as defined under HIPAA in order to collect fees that I owe **THE PRACTICE** for services rendered.

I hereby authorize Mayer J. Saad, M.D. P.C. to bill the credit card provided for outstanding balances on my account. This authorization will remain effective until revoked in writing by the card holder.

[ ] I acknowledge that the refusal to provide a valid credit card will make me responsible for payment within 30 days.

______________________________	____________________	____________________
CREDIT CARD NUMBER	**EXPIRATION DATE**	**SECURITY CODE**

______________________________	______________________________
PATIENT SIGNATURE	**DATE**
______________________________	______________________________
PRINT PATIENT NAME	**PATIENT'S ACCOUNT NUMBER**