WOMEN'S CARE OF BEVERLY HILLS MEDICAL GROUP

OBSTETRICS-GYNECOLOGY AND INFERTILITY

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PATIENT NAME:________________________________DATE OF BIRTH:________________

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I have received a copy of the Notice of Privacy Practices for the medical practice of Women's Care of Beverly Hills Medical Group. Our practice reserves the right to modify the privacy practices outlined in the notice.

   Please initial:X__________

2. **AUTHORIZATION TO RELEASE INFORMATION:** I agree that my physician and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and to make copies of my medical records.

   Please initial:X__________

3. **AUTHORIZATION TO PAY INSURANCE BENEFITS:** I hereby give my authorization to bill my insurance carrier and if applicable, I authorize payment to be made directly to Women's Care of Beverly Hills Medical Group.

   Please initial:X__________

4. **NON-CANCELLED APPOINTMENTS:** I understand that when I make an appointment and do not cancel within 24 hours of said appointment, I will be charged $50.00 because another patient could have been given that appointment time.

   Please initial:X__________

5. **FINANCIAL AGREEMENT:** I hereby agree to pay all statements not covered by insurance for services rendered by the physicians and medical staff at the end of each medical service. Any balance not paid within 30 days of receipt of statement will be considered in default, unless financial arrangements have been made with our billing department in advance.

   Please initial:X__________

6. **SPECIAL LETTERS AND FORM COMPLETION:** I understand that if I request a letter describing any medical conditions and/or treatments, including disability paperwork, I will be charged a minimum of $50.00.

   Please initial:X__________

The undersigned certifies that he/she has read the foregoing, receiving a copy if requested thereof, and is the patient or is authorized by the patient's general agent to execute the above and accept its terms.

Signature:________________________________ Date:______________________

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