Women's Healthcare Associates

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PATIENT ELIGIBILITY FORM

I, the undersigned, do hereby agree to be financially responsible for all charges incurred by me for professional services rendered to me. In the event I am not eligible under my health insurance or other form of health care coverage, I state to be eligible for such coverage at this time whether verifiable or not and agree to assume all financial responsibility for any and all services provided to me by the doctor.

Cancellation Policy: For all cancellations made within 24 hours of the appointment, there will be a $50.00 fee. For no-show appointments, the charge will be $50.00.

Signed:______________________________ Date:_______________

Print Name:__________________________

Witness: (sign)_______________________ Date:_______________

Print Name:__________________________