Please read the following statements and sign below

Statement of Financial Responsibility

Assignment of Insurance Benefits

I hereby authorize payment directly to Aventa Specialized Women's Care of all medical benefits otherwise payable to me on my behalf for the procedure(s) performed at Aventa Specialized Women's Care. I understand any unpaid deductibles, co-pays, or co-insurance amounts not payable by my insurance are my responsibility regardless of any pending insurance amounts. These amounts due from me are due on the date of service. This assignment of benefits is valid for insurance companies and programs, including Medicare.

Authorization of Release Information

I authorize Aventa Specialized Women's Care to release any and all medical information concerning the treatment performed at Aventa Specialized Women's Care as may be required by my insurance company in order to process payment of my claim(s).

Charges

I understand that standard charges have been established for all services at Aventa Specialized Women's Care. I further understand that the fee(s) for my treatment(s) and the charges will be billed to my insurance company. If any additional treatment is deemed necessary by my physician, and performed today, the treatment will be billed to my insurance company as well.

Credit Policy

Aventa Specialized Women's Care will file the appropriate claim forms to my insurance carrier. I will be notified when the final action (payment, denial, etc.) by my insurance carrier has been received. I understand that if my account becomes delinquent it will be placed with Prim & Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & ½ percent per month (18% PER ANNUM); (2) I agree and hereby consent that I will responsible for reasonable collection costs and attorney's fees in and costs of court incurred by the office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgement has been issued in a lawsuit and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid accordingly to policy I understand my credit history will be investigated and thoroughly reviewed.

I have read and understand the terms of this policy statment.

______________________________ ____________________
Patient Signature (Parent or Guardian if Minor) Date

______________________________ ____________________
Signature of Insured if other than Patient Date

137 Clinic Drive
Dothan, Alabama 36303
phone 334-699-2229
fax 334-699-4084
web aventawoman.com