

**THE NON-MEDICARE PATIENT:** I/WE authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I/WE understand that the information used or disclosed may be subject to re-disclosure by Specialists for Women, or an attorney collecting on the debt created by the services received, and that it would then no longer be protected by federal privacy regulations. I/WE assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Specialists for Women. The assignment still remains in effect until revoked by me in writing. I/WE HEREBY WAIVE THE RIGHT TO REVOKE THIS ASSIGNMENT ONCE SERVICES ARE PROVIDED BY SPECIALISTS FOR WOMEN. A photocopy of this assignment is to be considered as valid as the original.

**THE MEDICARE PATIENT:** I/WE request that payment of authorized Medicare benefits be made to me or on my behalf to Specialists for Women, for any services furnished me by that provider. I/WE authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment still remains in effect until revoked by me in writing. I/WE HEREBY WAIVE ALL RIGHT TO REVOKE THIS ASSIGNMENT ONCE SERVICES ARE PROVIDED BY SPECIALISTS FOR WOMEN. A photocopy of this assignment is to be considered as valid as the original.

**PAYMENT DUE WHEN SERVICES RENDERED:** Payment is due on the day services are received. Cash, check or credit card payment received on date of service may receive a discount at the sole discretion of Specialists for Women in appreciation of the prompt payment. Clients who present checks that are returned or do not make payments when services are received will not receive any discretionary discount and will be billed for the full amount due for the services received in addition to collection costs.

**APPLICATION OF PAYMENTS:** All payments shall be applied first to the payment of any interest, collection costs or expenses of Specialists for Women due hereunder, then any late charge due hereunder, then to reduction of principal.

**LEGAL TENDER:** All payments hereunder shall be payable in lawful money of the United States which shall be legal tender for public and private debts at the time of payment.

**SEVERABILITY:** In the event any covenant, term, or condition of this agreement shall be held for any reason to be invalid, illegal, or unenforceable in any respect, the invalidity, illegality, or unenforceability of such covenant, term, or condition shall not affect the validity, legality or enforceability of the remaining covenants, terms, and conditions of this agreement.

**GOVERNING LAW:** This agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia.

**FAILURE TO EXERCISE RIGHTS:** Any failure by Specialists for Women to exercise any right hereunder shall not be construed as a waiver of the right to exercise the same or any other rights at any time.

**BANKRUPTCY:** Patient or Guarantor specifically warrant that a bankruptcy proceeding is not in progress nor expected.

**CHANGE OF ADDRESS:** Patient or Guarantor specifically warrant that he/she will notify Specialists for Women of a change of address within five (5) days of changing an address by written notice to Specialists for Women.

**APPOINTMENT CANCELLATION FEE:** I/WE understand that if I/WE do not reschedule or cancel an appointment within 24 hours prior to the scheduled appointment I/WE agree to a charge of \$50.00 for time/service loss to the Physician.

**SURGERY AND PROCEDURE FEE:** I/WE understand that if I/WE cancel a surgery and/or procedure, I/WE agree to the charge of \$250.00 for time/services loss to the Physician.

**Acknowledgement of Privacy Practices**

By signing below, I \_\_\_\_\_, am acknowledging that a  
(Printed name)  
copy of Mid-Atlantic Women's Care Privacy Notice, pursuant to the Federal  
regulations known as the HIPAA Privacy Rule, is available upon request.

\_\_\_\_\_  
Signature

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date