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Dear ______________________________

Welcome to our office and we are looking forward to meeting you. Enclosed you will find a brochure that will give you background information on our office and our physicians. Also enclosed are a registration form and history form for you to complete. An arbitration agreement has been enclosed, please take time to read it. If you do not agree or have questions about this agreement please ask us at the time of your visit.
Please bring these completed forms to your appointment.

Patients who do not have insurance coverage or cannot furnish proof of insurance coverage will be required to pay in full at the time of service. You may call our billing department should you have any questions regarding insurance or payment issues.

If you have insurance coverage, please bring your insurance card(s) when you come to your appointment. If your deductible has not been satisfied, you will be required to pay for the contracted amount of the services rendered at the time of the visit. Your co insurance and or co-payment amount will be collected also. If you have any questions regarding which services are covered by your insurance, please call them prior to your appointment. We do not verify your benefits at the time of your appointment. In addition, you need to be aware of which laboratories your insurance company is contracted with for outside lab services. This will prevent your receiving uncovered expenses from the laboratory.

As a courtesy, our office will bill your insurance company. However, in the event that your insurance fails to pay for our services, the balance will be your responsibility. We accept cash, checks, Visa or MasterCard. A $10.00 service fee will be charged if it is necessary to bill you for your co-pay.

The fee for Ace parking is $3.00 for the first four hours. You will find parking in the front, on the side and under the building.

Again, welcome to our office. **Please check in 15 minutes prior to your scheduled appointment time.** If we can be of further assistance before your appointment, please do not hesitate to call.

Appointment Information

Mon ___ Tues ___ Wed ___ Thurs _____ Fri _____

Date________________________ at ____________

Doctor__________________________

A 24-HOUR NOTICE IS REQUIRED BY WOMEN'S HEALTH CARE WHEN UNABLE TO KEEP YOUR APPOINTMENT. WE RESERVE THE RIGHT TO NOT RESCHEDULE THE APPOINTMENT IF THIS POLICY IS NOT FOLLOWED. FURTHMORE, PATIENS WHO FAIL TO CANCEL OR RESCHEDULE THEIR APPOINTMENTS 24 HOUR IN ADVANCE ARE SUBJECT TO A $25 CHARGE.

***X*____ *Date* _____________________________**