Certification of Voluntary and Informed Consent

Abortion Instructions and Informed Consent Form

Also available in Spanish

Kansas Department of Health and Environment
1000 S.W. Jackson, Suite 220
Topeka, Kansas 66612-1274
Toll Free 1-888-744-4825

Available online: www.womansrighttoknow.org

INSTRUCTIONS
FOR CERTIFICATION OF VOLUNTARY AND INFORMED CONSENT FORM

This form is in compliance with the Woman's Right to Know Act (K.S.A. 65-6708 et seq.) and is an important legal document. Properly prepared, it is proof that the physician or qualified agent of the physician complied with the statutory requirement that the pregnant woman received complete information about her alternatives and voluntarily consented to an abortion at least 24 hours prior to having the abortion. Complete the form in accordance with the following instructions:

- All entries must be in ink. Type, print or stamp all entries other than the pregnant woman's confirmation initials, signatures, dates and times.
- In the upper left hand corner, enter the name and address of the facility. A stamped name and address is acceptable.
- In Sections I and II, type, print or stamp the name of the individual who presented the information and indicate whether that person is the physician who will perform the abortion, referring physician, or other qualified person by entering check marks in the appropriate spaces. Have the pregnant woman read the sections and initial in the spaces provided to acknowledge receipt of information.
- In Section III, type, print or stamp the name of the physician who will perform the abortion. Have the pregnant woman read the section and initial in the space provided to acknowledge receipt of information

The CERTIFICATION OF VOLUNTARY AND INFORMED CONSENT - ABORTION form is composed of instructions and a consent form. If information or materials are provided by a referring physician, that person retains the original. It is recommended that the referring physician retain the original as part of the patient's medical records. Give a copy to the patient with verbal instructions to take it to the physician who is to perform the abortion. It is recommended that this physician also retain a photocopy of this consent form and make it a part of the patient's medical record. The CERTIFICATION OF VOLUNTARY AND INFORMED CONSENT - ABORTION (on the following pages) should not be sent to Kansas Department of Health and Environment (KDHE).

The INDUCED TERMINATION OF PREGNANCY, PHYSICIAN'S REPORT ON NUMBER OF CERTIFICATIONS RECEIVED form must be submitted monthly by the physician accepting referral and who performs the abortion to the:

Kansas Department of Health and Environment, Bureau of Epidemiology and Public Health Informatics
1000 SW Jackson, Ste. 100
Topeka, Kansas 66612

Questions and/or comments may be submitted to the KDHE/BFH, 1000 SW Jackson Street, Ste 220, Topeka, KS 66612-1274 or toll-free 1-888-744-4825.

Name and address of facility:
Center for Women's Health
4840 College Blvd.,
Overland Park KS 66211

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
2011 Legislative Session, amended K.S.A. 65-6709 and K.S.A. 65-6710

VOLUNTARY AND INFORMED CONSENT FORM

Please initial each section to indicate the information was provided.

Initials:

_____ **SECTION I. The following information was presented to me in writing at least 24 hours before the abortion by Dr. Traci Nauser, who is the physician who is to perform the abortion.**

1. The name of the physician who will perform the abortion;

2. a description of the proposed abortion method;

3. a handbook titled, If You Are Pregnant (available in print form and on-line);

4. description of the risks related to the proposed abortion method, including risks to my reproductive health and alternatives to the abortion that a reasonable patient would consider material to the decision of whether or not to undergo the abortion;

5. the probable gestational age of the unborn child at the time the abortion is to be performed and that Kansas law requires the following: No person shall perform or induce an abortion when the unborn child is viable unless such person is a physician and has a documented referral from another physician not legally or financially associated with the physician performing or inducing the abortion and both physicians determine that: (1) the abortion is necessary to preserve the life of the pregnant woman; or (2) a continuation of the pregnancy will cause substantial and irreversible impairment of a major bodily function of the pregnant woman, and no person shall perform or induce a partial birth abortion on a viable unborn child unless such person is a physician and has a documented referral from another physical not legally or financially associated with the physician performing or inducing the abortion and both physicians determine: (1) The abortion is necessary to preserve the life of the pregnant woman; or (2) a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant women. If the child is born alive, the attending physician has the legal obligation to take all reasonable steps necessary to maintain the life and health of the child;

6. the probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

7. the contact information for free counseling assistance for medically challenging pregnancies and the contact information for free perinatal hospice services;

8. the medical risks associated with carrying an unborn child to term; and

9. any need for anti-Rh immune globulin therapy, if I am Rh negative, the likely consequences of refusing such therapy and the cost of the therapy.

Initials:

_____ **SECTION II. The following information was presented to me in writing at least 24 hours before the abortion by Dr. Traci Nauser who is the physician who is to perform the abortion.**

1. A handbook titled, If You Are Pregnant: Directory of Available Services (available in print form and on-line) including a list of agencies which offer alternatives to abortion including adoption services;

2. medical assistance benefits may be available for prenatal care, childbirth and neonatal care, and more detailed information on the availability of such assistance is contained in the printed materials given to me and described in K.S.A. 65-6710, and amendments thereto;

3. the father of the unborn child is liable to assist in the support of my child, even in instances where he has offered to pay for the abortion (in the case of rape this information may be omitted);

4. I am free to withhold or withdraw my consent to the abortion at any time prior to invasion of the uterus without affecting my right to future care or treatment and without the loss of any state or federally-funded benefits to which I might otherwise be entitled; and,

5. an abortion terminates the life of a whole, separately unique, human living being.

Initials:

_____ **SECTION III.** At least 30 minutes prior to the abortion procedure, prior to physical preparation for the abortion and prior to the administration of medication for the abortion, I met privately with the physician who is to perform the abortion and such person's staff and I had an adequate opportunity in my own language to ask questions and obtain information from the physician concerning the abortion.

Initials:

_____ **SECTION IV.** At least 30 minutes prior to the abortion procedure, the physician informed me that ultrasound equipment is used preparatory to the performance of an abortion, my right to view the ultrasound image at no additional expense, and my right to receive a picture of the image at no additional expense.
Ultrasound used: ❑ yes
I requested to view image: ❑ yes ❑ no
I requested a physical picture: ❑ yes ❑ no

Patient Signature: _____Date: _____ Time: _____A.M. or P.M. (circle one)

Initials:

_____ At least 30 minutes prior to the abortion procedure, the physician informed me: that heart monitor equipment is used preparatory to the performance of an abortion, and my right to listen to the heart-beat at no additional expense.
Heart monitor equipment used: ❑ yes
I requested to listen: ❑ yes ❑ no

Patient Signature: _____Date: _____ Time: _____A.M. or P.M. (circle one)

This certification required by K.S.A. 65-6709 shall be placed in the woman's medical file in the physician's office and kept for 10 years or in the case of a minor 5 years past the minor's majority, but in no event less than 10 years.

Rev. 7/11

INFORMED CONSENT for ABORTION PROCEDURE

IN accordance with KANSAS LAW (SB 204), the following information is being provided to you in written form at least twenty-four (24) hours prior to an elective abortion procedure to be performed by: Traci L. Nauser, MD of Overland Park, Kansas.

THE abortion procedure will be that of a Dilatation and Suction Curettage ("D & C") or a Dilation and Evacuation ("D & E"). The doctor will perform the abortion procedure by numbing the cervix with injections of lidocaine, a local anesthetic. After waiting several minutes for the medication to take effect, the doctor will dilate the cervical opening to the uterus using sterile rods. Tubing attached to a suction machine will then be used to remove the pregnancy tissue from the uterine cavity. Special forceps will be used in the "D & E" procedure to remove fetal tissue. A metal instrument called a curette may also be used to gently scrape the uterine walls. The actual procedure takes from 30 seconds to three to five minutes, depending on the number of weeks of the pregnancy.

The HEALTH RISKS of an abortion are much less than those of other surgical procedures, and far less than those associated with a full-term pregnancy and delivery. SOME of the possible complications include:

Retained Clots or Tissue; necessitating a repeat "D &C"	less than 1 per 100 patients
Hemorrhage (excessive bleeding), or Infection	less than 1 per 350 patients
Allergic Reaction to Medication	less than 1 per 500 patients
Laceration of the Cervix requiring sutures	less than 1 per 500 patients
Missing an Ectopic ("Tubal") Pregnancy	less than 1 per 600 patients
"Missing" an early Pregnancy	less than 1 per 1000 patients
Uterine Perforation, Organ Damage, Hospitalization, Major Surgery, Blood Transfusion, Emergency Hysterectomy, future Sterility	less than 1 per 10,000 patients
DEATH	less than 1 per 200,000 patients

FOR full-term pregnancies, the death rate following a vaginal delivery is around 15 per 100,000; and 30 per 100,000 for Cesarean Section deliveries (the rate of Cesarean Section is about 1 out of 4 deliveries). There is no credible scientific evidence that abortion causes breast cancer or preterm birth in subsequent pregnancies.
TODAY, you have Four (4) CHOICES:
1. WAITING and thinking more about your decision.
2. CONTINUING the pregnancy, and planning for an ADOPTION.
3. CONTINUING the pregnancy, and BECOMING A PARENT.
4. ENDING the pregnancy, by having an ABORTION.

ALSO provided to you and listed below are some COMMUNITY RESOURCES available to support your decision to carry the pregnancy to full term. The Kansas Department of Health & Environment may be able to provide further assistance.

BASED on the information you provided to us today, you are approximately _____ weeks pregnant (plus or minus 1 week).

IF you carry the pregnancy to full-term, you would DELIVER on approximately: _____ / _____ / _____ (plus or minus 1 week).

_____**I am not seeking to have an abortion solely on account of the sex of the fetus.**
I CERTIFY that I received this information IN WRITING at least 24 HOURS PRIOR to the performance of an abortion procedure upon me by Dr. Traci L. Nauser, M.D. or the staff of Center for Women's Health.

Signed _____ Time received _____ AM/PM Date received _____

please see next page

INFORMED CONSENT for ABORTION PROCEDURE

ALL PAPERWORK MUST BE COMPLETELY FILLED OUT BEFORE YOUR APPOINTMENT AND BRING ALL OF IT BACK WITH YOU DO NOT MAIL IT BACK TO US. Due to the time you will be in our office only ONE support person per patient DO NOT BRING CHILDREN.

YOU MUST BRING A PHOTO I.D. SHOWING YOUR DATE OF BIRTH.

ALL fees must be paid in CASH before the procedure. NO Checks or Money Orders. VISA or MasterCard may be used.

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR APPOINTMENT!

COMMUNITY RESOURCES AVAILABLE TO ASSIST YOU, IF YOU DECIDE TO CONTINUE THE PREGNANCY

KANSAS:
Christian Family Services (913) 491-6751
K. U. Medical Center 588-6290
Right to Life of Eastern Kansas 299-9047
Johnson Co. Health Dept. (Mission) 791-5660
Johnson Co. Health Dept. (Olathe) 782-9400
Wyandotte Co. Health Dept. 321-4803
Douglas County Health Dept. (785) 843-0721
Franklin County Health Dept. (785) 242-1873

MISSOURI:
Birthright (816) 444-7090
Truman Medical Center (West) 556-3516
Truman Medical Center (East) 478-1180
Missouri Right to Life 353-4113
L.I.G.H.T. House 361-2233
Jackson Co. Health Dept. 881-4424
Clay Co. Health Dept. 781-1600
Platte Co. Health Dept. 329-5759

24-HOUR INFORMED CONSENT for ABORTION

***BRING* THIS DOCUMENT WITH YOU TO YOUR APPOINTMENT. *INITIAL* EACH SECTION & SIGN THE BOTTOM**

DO NOT MAIL IT BACK TO OUR OFFICE!

To comply with Kansas Law *{effective July 1, 1998, July 1, 2009, and July 1, 2013} (amended July 1, 2011, July 1, 2013, July 1, 2017), you must receive this* Informed Consent *at least 24 hours prior to your procedure.*

YOU MUST PRINT THIS FORM EXACTLY AS IT APPEARS, USING BLACK INK AND WHITE PAPER. ANY CHANGE TO THE FONT OR THE FONT SIZE OR FAILURE TO PRINT THIS FORM ON WHITE PAPER USING BLACK INK, MAY DELAY YOUR ABORTION APPOINTMENT BY AT LEAST 24 HOURS.

1. _____ Traci L. Nauser, MD will be the physician who is to perform the abortion. She received her medical degree in 1994. She has been employed at the Center for Women's Health since August 1, 1998.

Has Traci L. Nauser, MD had any disciplinary action by the Kansas Board of Healing Arts? ❑ Yes ■ No

Does Dr. Nauser carries malpractice insurance as required by the state of Kansas? ■ Yes ❑ No

Does Dr. Nauser have clinical staff privileges located within 30 miles of the facility where the abortion is to be performed? ■ Yes ❑ No

Below is a list of the hospitals where Dr. Nauser has clinical staff privileges:

Menorah Medical Center original approval date August 26, 1998
Saint Luke's South Hospital original approval date January 1, 1999
Overland Park Regional Medical Center original approval date September 4, 1998

Has Dr. Nauser lost privileges at any hospital? ❑ Yes ■ No
Is Dr. Nauser a resident of the state of Kansas? ■ Yes ❑ No

2._____ You will have the opportunity to **meet with the doctor** before your procedure.

3._____ **Estimated Gestation of Pregnancy**: Until you have a sonogram at our office to determine how far along you are, the best way to **estimate** the gestation is by the date of the **1st** day of your **last normal menstrual period.**

24-HOUR INFORMED CONSENT FOR ABORTION

If you believe your last normal menstrual period STARTED:	Then you are probably about:	If you believe your last normal menstrual period STARTED:	Then you are probably about:
4 weeks ago	4 weeks pregnant	14 weeks ago	14 weeks pregnant
5 weeks ago	5 weeks pregnant	15 weeks ago	15 weeks pregnant
6 weeks ago	6 weeks pregnant	16 weeks ago	16 weeks pregnant
7 weeks ago	7 weeks pregnant	17 weeks ago	17 weeks pregnant
8 weeks ago	8 weeks pregnant	18 weeks ago	18 weeks pregnant
9 weeks ago	9 weeks pregnant	19 weeks ago	19 weeks pregnant
10 weeks ago	10 weeks pregnant	20 weeks ago	20 weeks pregnant
11 weeks ago	11 weeks pregnant	21 weeks ago	21 weeks pregnant
12 weeks ago	12 weeks pregnant	21.6 weeks ago	21.6 weeks pregnant
13 weeks ago	13 weeks pregnant		

The final determination will be made by our doctor upon ultrasound examination. If you are between **4-7 weeks, a Medical Abortion may be done**. Between **4-14 weeks** the usual procedure is Vacuum Aspiration **("D&C")**. If you are between **15-21.6 weeks** the most common procedure is Dilation and Evacuation **("D&E")**.

4._____TYPES of Abortion Procedures:

Medical Abortion: This is done using *Mifeprex*, taken by mouth. This medication stops the growth of the pregnancy. Two days later you will take a second medication, *misoprostol*, to cause your body to expel the pregnancy tissue. If you have a medical abortion, you must agree to end the pregnancy if the medication fails. You must agree to return for a check-up two weeks after you take the *Mifeprex*.

First Trimester (4 - 13 weeks LMP) "Suction D&C" This procedure begins with a local anesthetic given to numb the cervix. The cervix is then widened using dilators, which are tapered rods that gradually increase in size. The physician inserts a small tube (cannula) into the uterus. The suction device empties the contents of the uterus through the tube. The physician may check the walls of the uterus with a curette. The entire procedure takes less than 2 minutes. Sensations will vary, but they are described as cramping or discomfort, which generally subsides within a few minutes after the procedure is over.

Second Trimester (14 - 21.6 weeks LMP) Dilation & Evacuation ("D&E") During the first appointment; one or more osmotic dilators ("laminaria") are inserted into the cervix to begin the process of slow, gentle dilation of the cervix. The abortion procedure occurs several hours later (or the next morning) and involves removal of the pregnancy tissue with forceps. A suction instrument is also used to clean the uterus, and a curette is used to check the uterine walls. Patients are then monitored in a recovery area following the procedure.

5._____ COMPLICATIONS of ABORTION: Possible complications include: blood clots accumulating in the uterus, requiring another suction procedure; infections, most of which are easily identified and treated if the woman carefully observes follow-up instructions; a tear in the cervix, which may be repaired with stitches; perforation of the wall of the uterus, which may heal itself or may require surgical repair or, rarely, hysterectomy; and abortion that is not complete, or that does not completely end the pregnancy and may require the procedure to be repeated; failure to detect a pregnancy outside of the uterus; excessive bleeding due to failure of the uterus to contract, which may require a blood transfusion; up to and including death. In the second trimester, risks increase with every week of gestation.

6_____ RISKS with terminating a pregnancy vs. carrying a pregnancy to term. Health risks are low with either decision. There is approximately 1 death for every **200,000** women who have a legal abortion. These rare deaths are usually of adverse reactions to anesthesia, heart attacks, or uncontrollable bleeding. The death rate for a woman carrying a pregnancy to term is about **20-30 times higher**. There is **NO** credible scientific evidence that abortion causes breast cancer or pre-term birth in subsequent pregnancies.

7._____Your **BLOOD TYPE** will be determined the day of your appointment. Approximately 15% of the population is Rh negative. All Rh-negative women will receive an injection of **Rh Immune Globulin (RhoGAM®)** to prevent problems with future pregnancies such as miscarriage, severe fetal anemia or permanent fetal damage. The cost of the **Rh Immune Globulin** is **$100 - $150**, depending on the duration of the pregnancy.

8._____ACCORDING to KANSAS LAW, effective July 1, 1998; amended July 1, 2009; amended July 1, 2011, July 1, 2013, July 1, 2017:

A. **INFORMATIONAL MATERIALS** are available in printed form and online at *womansrighttoknow.org* and *kansaswomansrighttoknow.org*, describing the fetus and listing agencies which offer alternatives to abortion with a special section listing adoption services, national perinatal assistance, and a list providers of free ultrasound service and free perinatal assistance.

B. **ALTERNATIVES to ABORTION** include: parenting, foster care and adoption. Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care. More detailed information on the availability of such assistance is contained in the printed informational materials you received from Center for Women's Health, or online at: *womansrighttoknow.org* and *kansaswomansrighttoknow.org*, For information on Kansas perinatal resources go to *www.kdheks.gov/c-f/maternal.html*. For national perinatal resources go to *www.nationalperinatal.org* and *www.brightfutures.org*.

C. "…**the father of the fetus** is liable to assist in the support of the child even in instances where he has offered to pay for the abortion..."

D. "…the abortion will terminate the life of a whole, separate, unique, living human being..."

E. "…**the woman is free to withhold or withdraw her consent** to the abortion at any time prior to the invasion of the uterus without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she might otherwise be entitled..."

F. "…No person shall perform or induce an abortion when the fetus is viable **(>22 weeks**) unless such person is a physician and has a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that: 1) the abortion is necessary to preserve the life of the pregnant woman; or 2) a continuation of pregnancy will cause substantial and irreversible physical impairment of a major bodily function of the pregnant woman…" And, "…No person shall perform or induce a partial birth abortion on a viable fetus (>22 weeks) unless such person is a physician and has documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion and both physicians determine that: 1) the abortion is necessary to preserve the life of the pregnant woman; 2) a continuation of pregnancy will cause substantial and irreversible impairment of a major physical or mental function of the pregnant woman..." If the child is born alive, the attending physician has the legal obligation to take all reasonable steps necessary to maintain the life and health of the child…"

G. The State of Kansas requires us to make the following statements, which we believe to be medically inappropriate, misleading, and ideologically motivated. We are currently challenging the validity of this requirement in court: "By no later than 20 weeks from fertilization, the unborn child has the physical structures necessary to experience pain. There is evidence that by 20 weeks from fertilization unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain. Anesthesia is routinely administrated to unborn children who are 20 weeks from fertilization or older who undergo prenatal surgery."

9._____I received this information at least twenty-four (24) hours prior to my procedure.

PLEASE COMPLETE the FOLLOWING: I RECEIVED THIS INFORMATION ON:

Patient's Signature _____ TODAY'S Date_____

PARENT/GUARDIAN & MINOR CONSENT

1. **WE** hereby swear under oath (or, affirm) that WE: _____ **AND**
(Parent #1)

_____, are the parents (or, legal guardian) of: _____,
(Parent #2) (Daughter/Ward)

who was born on: _____.
(Date of Birth)

2. **WE** have been informed that Traci Nauser, MD intends to perform an abortion to terminate the pregnancy of: _____ **at her request**, and **WE** consent to her decision.
(Daughter/Ward)

3. **WE** understand **BOTH** parents of: _____ must consent.
(Daughter/Ward)

4. **WE are the persons, under Kansas Law, required to consent.**

"…Except in the case of a medical emergency… no person shall perform an abortion upon an unemancipated minor, unless the person first obtains the notarized written consent of the minor and both parents, or the legal guardian of the minor…."

_____	_____	_____
Parent #1 Name, Please Print	Parent #1 Signature	Date
_____	_____	_____
Parent #2 Name, Please Print	Parent #2 Signature	Date
_____	_____	_____
Minor/Parent Name, Please Print	Minor/Parent Signature	Date

(State) of: _____

(County) of: _____

Signed and sworn to (or affirmed) before me by:

This _____ day of _____, 20_____.

_____ ***(SEAL)***
(Notary Public)

My appointment (commission) expires: _____.

In accordance with patient confidentiality and privacy laws, we will need your written permission to discuss appointments, test results, medical records, prescriptions and your account information with anyone other than yourself. Please ***LIST BELOW ANYONE*** you give permission to access your information (**including billing/account balance information**) by phone, fax or mail.

- ❏ No one (I understand this includes spouse/doctors/etc.)
- ❏ Spouse/Children _____
- ❏ Other _____

I understand that I have the right to revoke this authority at anytime, but I must do so in writing. The revocation does not apply to any information already released.

_____ _____ _____

Signature of Patient or Legal Guardian/Parent Relationship Date

I hereby acknowledge that I have been offered a copy of Center for Women's Health Notice of Privacy Practices.
Initial_____ Date_____

CONSENT TO CORRESPOND ELECTRONICALLY

While Center for Women's Health takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge if I use electronic mail to initiate contact with Center for Women's Health regarding my medical care, the physician and/or his representatives have my permission to correspond via that email address.

I give permission for Center for Women's Health physician and/or staff members to email me at _____ @ _____ regarding my medical care.

AUTHORIZATION FOR TREATMENT

I hereby authorize medical treatment for myself or my dependent as deemed necessary by the providers of Center for Women's Health.

PHARMACY BENEFIT MANAGEMENT CONSENT

In order to ensure we have the most accurate and up-to-date information on your medication, we are able to import all of your current medications directly from your pharmacy(s) into our Electronic Health Records via a SECURE connection. We will continue to verify your medications, but importing them electronically saves you and our staff time. By providing us with your signature below, you are authorizing us to import your medications on your behalf. I hereby authorize Center for Women's Health to import my medications from my pharmacy(s) into their electronic health record.

By signing this consent form you are agreeing that Center for Women's Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

AUTHORIZATION/ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private, HMO/PPO, and commercial insurances as well as third party payors be made on my behalf to Center for Women's Health for any services furnished to me or my family by Center for Women's Health. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment or for determination of benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original.

_____	_____	_____	_____
Signature of Patient or Legal Guardian/Parent	Relationship	Date	Center for Women's Health Representative Signature (verified)

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. Any balances, co-pay and/or deductibles are due prior to seeing the physician. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. You also understand you are responsible for any amount not covered by your insurance. In the event your insurance company requests a refund of the payment made, you will be responsible for the entire charge amount. Our office makes no guarantee of benefits. Any quoted benefits provided by your insurance company are considered general overview and only a guideline until payment is received. All services are subject to review by the insurance company once a claim is received and they determine if a payment will be made.

A parent who brings a minor child to our office for medical care is legally responsible for payment of all charges.

If you do not have insurance, payment is expected when services are rendered. If payment in full is not possible at the time services are rendered, payment arrangements may be made in advance. You must notify the office prior to your appointment if you are unable to pay in full.

I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, interest, and attorney fees.

I understand if I am unable to make a scheduled appointment I must cancel within 24 hours of my appointment time. I understand if appointments are repeatedly missed, Center for Women's Health may be forced to dismiss me from the practice.

Center for Women's Health accepts payments in the form of credit card (Discover, Visa and MasterCard) or cash. We do not accept checks.

CREDIT CARD ON FILE POLICY

At Center for Women's Health, we require keeping your credit or debit card on file as a method of payment for the portion of services your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Center for Women's Health to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

❏ Visa ❏ MasterCard ❏ Discover Card Number _____ Expiration Date ____ / ____

Cardholder Name _____ Signature _____

Billing Address _____ City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Center for Women's Health to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me or my dependents by Center for Women's Health. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a notification to Center for Women's Health in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____

I have read the above information. **I understand my responsibilities for the payment of my account.**

_____	_____	_____	_____
Signature of Patient or Legal Guardian/Parent	Relationship	Date	Center for Women's Health Representative Signature (verified)