Women's Health Connecticut
Thameside ObGyn Centre
Member of Women's Health Connecticut

**Correct Current Insurance Information & Payment Agreement**

I, _____ am scheduled to be seen by _____
Patient Name Providers Name

today, _____
Date

And did

- ☐ provide my health/insurance card
- ☐ provide evidence of insurance coverage
- ☐ meet my health plans requirement(s) for my OB/GYN physician to be paid

I understand that all charges incurred on _____ will be my responsibility until
Date of visit
this information is provided and/or that all my obligations to ensure reimbursement by my insurance plan are met. If I do not provide this office with correct and current insurance information before my insurance plans filling limit expires, and/or if I choose to receive services more often than what will be reimbursed by my insurance, I am aware an agree to be fully responsible for payment of all associated charges.

_____ _____
**Signature** **Date**

## Patient Decline Submission of Charges to Insurance

I, _____ am scheduled to be seen by _____
Patient Name Providers Name

today, _____ due to the sensitivity of my medical information and/or personal
Date
reasons I elect to decline the submission of these charges to my insurance company which may reimburse these services. Instead, I agree to be personally and fully responsible for payment of all associated charges, _____.
Total Charges

_____ _____
**Signature** **Date**