Park West Women's Associates, PLLC
12606 West Houston Center Blvd., Suite 120
Houston TX 77082
O: 713.640.5922 F: 713.640.5982

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEGEMENT

1. I understand that full payment, co-payments, and/or deductibles are due at the time of service and collected prior to rendering service.
2. I have the following options to pay for my services: Cash, Checks, Bank Debit Card, MasterCard, Visa, Discover, and/or American Express.
3. I understand that returned checks will incur a $40.00 charge.
4. I understand that there are no payment plans**.**
5. **Obstetrics patients** (self pay or high deductible balance): Full payment is expected by the 28th week of pregnancy. Otherwise, your maternity care will be terminated and any outstanding balance(s) will be forwarded to a collection agency.
6. I will provide the most current and accurate information about myself and my private insurance plan or Medicaid/ Medicare plan. I will notify Park West Women's Associates, PLLC immediately of any changes to my coverage and/or contact information such as address, phone number, E-mail.
7. I will not give false information about myself or my health coverage plan. Such an act is reportable to authorities and insurance company(s). This will lead to termination of medical services at Park West Women's Associates, PLLC.
8. I agree to call to cancel or reschedule my appointment at least 24 hours in advance if I am unable to keep that appointment. There is a $25.00 fee for missed appointment.
9. I understand that medical records may be release to me or designated individual(s) with a $25.00 fee and allow 48-72 hours minimum.
10. I understand that forms such as FMLA will be completed if needed with a $25.00 fee and allow 48-72 hours minimum.
11. I understand that persistent outstanding balances will be turned over to an outside collection agency and I am liable for collection cost as well.
12. I agree to bring my current private insurance, medicaid, or medicare card **and** state/ government issued picture identification (driver's license, passport, or identification card) to every appointment.

_____	_____
Patient Name (please print)	Witness Name (office staff)
_____	_____
Patient Signature	Witness Signature
_____	_____
Date	Date