Health Care Consent Policy

Due to the ever-changing nature of health insurers and insurance plans, I understand that it is my responsibility to contact my insurance carrier to confirm that Associates in Women's Health is in network with my plan. If Associates in Women's Health is NOT in network, I understand and agree that I am responsible for the entire balance for my care.

Patient Signature: _____

Patient name (print): _____

Date: _____

Insurance:_____

Staff initials:_____