

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____

INSURED NAME: _____

ID/SS#: _____ **GROUP NAME/#:** _____

SECONDARY INSURANCE COMPANY: _____

INSURED NAME: _____

ID/SS#: _____ **GROUP NAME/#:** _____

We will photocopy the front and back of your insurance card(s).

I designate
NORTHWEST PROFESSIONAL OBSTETRICS AND GYNECOLOGY, LTD.
RICHARD J. LEVY, M.D., F.A.C.O.G.
KAREN L. COLLINS, M.D., F.A.C.O.G.
As my woman's principal health care provider.

Signed: _____ Dated: _____

NORTHWEST PROFESSIONAL OBSTETRICS AND GYNECOLOGY, LTD. will file an insurance claim using carrier information I have supplied today. I understand that if my insurance denies or does not consider my claim, I am fully and personally responsible for payment. Signature of patient or authorized person certifies financial responsibility for all medical services provided and authorizes release of medical or other insurance information necessary for the processing of medical claims for payment by the carrier. Patient or authorized person acknowledges and understands that interest will be charged in the amount of 1.75% per month (21% annually) on all past due amounts.

Signed: _____ Dated: _____