

*INSURANCE INFORMATION*

**PRIMARY INSURANCE COMPANY:**-----

Insured Name:-----

I.D./SS #:----- Group Name/#:-----

**SECONDARY INSURANCE COMPANY:**-----

Insured Name:-----

I.D./SS #:----- Group Name/#:-----

*We will take a machine copy of the front and back of your insurance card (s).*

*I designate NORTHWEST PROFESSIONAL OBSTETRICS AND GYNECOLOGY, LTD.*

*Richard J. Levy, M.D.*

*Regina Belmonte, M.D.*

*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:-----