Northern Virginia Physicians to Women, Ltd.

Obstetrics & Gynecology

Date: _____

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary medical information for related claims to:

Name of Insurance Carrier: _____

Effective Date of Policy: _____

I understand if complications arise with my insurance coverage, I will cooperate fully with NVPW to resolve any issue. I understand that I am responsible for copayments, deductibles or any non-covered services which can be collected at the time of my appointment; outstanding balances are due within 30 days upon receipt of my statement. I understand that I may revoke this authorization at any time, in writing.

I authorize payment of benefits to Northern Virginia Physicians to Women, Ltd.

Patient Signature: _____

Name of Policyholder: _____

Relationship to Policyholder: _____

Policyholder's Date of Birth: _____

Policyholder's SSN: _____