Agreement addendum:

I accept responsibility for any charges associated with this and all visits. I understand that I must present my insurance card and photo identification at each visit or my appointment will be rescheduled.

I understand that I must give at least a 24 hours advance notice if I am unable to make it to any of my appointments. I understand that if I fail to cancel it ahead of time a $30 fee will be charged to my account.

I understand that if I fail to show up for an appointment, a $50 fee will be charged to my account.

I understand that if I cancel a surgical procedure less than 24 hours from the scheduled time, a $100 fee will be charged to my account.

I understand that once my insurance company has processed my claims I am responsible for the balance due. If I do not make an approved monthly payment on my balance, I will be charged a $30 monthly fee.

I understand that if I decide to transfer my care to another physician's office, a record release fee of $25 and any outstanding balance with OBGYN of Westlake must be paid in full.

I also understand that if my account is past due over 90 days, and I have not made arrangements for monthly payments, my account will then be sent to a collection agency. I also understand that I will be charged $35 for all returned checks.

I understand that if any test result is not received by me within 3 weeks of testing, it is my responsibility to call the office for results. This includes imaging studies.

My signature on this form covers all dates of service and charges I incur with OBGYN of Westlake from this day forward.

_____ _____

Patient Signature Date