AIRPORT-PLAYA WOMEN'S MED GRP
8540 S. SEPULVEDA BLVD #1002
LOS ANGELES, CA 90045
310-670-2085

TAX ID: 953989531

DATE: _____

PATIENT: _____

Dear Ms. _____

It is the policy of this office to collect payments and/or copayments for services as they are rendered. This allows us to control our costs and keep fees at a reasonable level.

Whether or not your insurance can be verified, insurance verification DOES NOT GUARANTEE PAYMENT for services. We cannot render services only on the assumption that your charges will be paid for in full by your insurance company.

We will bill your insurance company for you as a courtesy. However, you are responsible for any/ all charges that are not covered by your insurance. If it is later revealed to us that your insurance coverage has been terminated, you will be responsible for FULL PAYMENT OF ALL CHARGES INCURRED.

I, the undersigned, have read the above statement and accept full responsibility for all medical charges incurred by me, or by my dependents, for services rendered by AIRPORT-PLAYA WOMEN'S MEDICAL GROUP, INC., unless those services are covered by my insurance plan.

This additionally shall serve as authorization to release to your insurance company any information requested to facilitate insurance payment processing.

SIGNATURE_____**DATE**_____