CONSENT FORMS

PRIOR CONSENT TO CONTACT YOU BY CELL PHONE:

You agree, in order for us to service your account or to collect monies you may owe Montgomery Women's Health Associates and/or agents may contact you by telephone numbers, which could result in charge to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devises, as applicable.

I/We have read this disclosure and agree that Montgomery Women's Health Associates, Its employees and/or agents may contact me/us as described above.

______________________________ __________________________

Responsible Party Date

NON-COVERED ROUTINE SERVICE POLICY AND AGREEMENT TO PAY

As your doctor, we want to provide you with the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by Medicare, BCBS or other insurance carriers. You will be expected to pay for those services in full. Be assured that we order only tests that are necessary for your treatment and care. Also, if your insurance requires an authorization or referral from your primary care practitioner, it is your responsibility to obtain this prior to your appointment. In the event no referral is obtained, you will be responsible for the services not covered.

All co-payments and non-covered services by insurance are due at the time services are rendered. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

______________________________ __________________________

Responsible Party Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/BCBS/or other insurance company benefits be made on my behalf to Montgomery Women's Health Associates for any services furnished me by that party/physician who accepts assignment. Regulators pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this authorization to be used and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party responsible for paying for my treatment. (Sec. 1128B of the SS Act and 31 USC 3801-3812 provides penalties for withholding this information.)

______________________________ __________________________

Responsible Party Date