



Consent for Treatment

Consent to Treat Patients and Release of Information

I authorize care and treatment by Valley Obstetrics and Gynecology and their health care providers. I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand I have a right to review Valley Obstetrics and Gynecology's Notice of Privacy Practices prior to signing this document.

Insurance Authorization and Terms of Account

Valley Obstetrics and Gynecology will bill customer's insurance company for them. In order to control the cost of billings, we request that the charges for office visits be paid at the conclusion of each visit. There will be a 1.75% interest charge per month (21% APR) with a minimum charge of \$1.00 for accounts 30 days past due or older. **Should any unpaid balance be referred to a collection agency, customer agrees to pay an additional 40% collection fee plus any attorney fees or court costs.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Valley Obstetrics and Gynecology. I assume responsibility to pay a deductible amount, co-insurance, or any other balance not paid for by my insurance.

Signature _____

Name (please print) _____

Date _____