<u>Advantage Women's Care</u>

Jennifer T. Nguyen, MD // Bih N. Ndofor, MD

19740 I-45 North, Spring, TX 77373

Office: 281-537-5556 Fax: 281-537-5560

Patient Payment Consent Form

Patient Name: ____ ____________

Name on card if different: ____

Card Number: __________-____________-___________-____________Exp. Date: __________

Security Code: ____________

Card Holder's Billing Address for Monthly Card Statements:

____

Street City/State Zip Code

I authorize **Advantage Women's Care, PA** to charge my Debit/ Credit Card for professional services as follows:

__ Full Fee for Service $ ___________

__ Co-pay Amount or Fees towards Insurance Deductible $ ___________

__ Payment towards Remaining Balance $ ____________

By signing this form, you also agree that you will be charged automatically for any No-Show or Cancellations less than 24 hours in advanced in the amount of $20.00.

Please be aware that unless an agreement is negotiated with the above provider (or representative), all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your Debit/ Credit Card.

Card Holder's Signature: ____________________________________ Date: ________________

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.