All American OB/GYN
413 Owen Drive Suite 101
Fayetteville, NC 28304
910-480-4880

CONSENT TO TREAT/FINANCIAL AGREEMENT

I agree that I am responsible for payment of all charges for health care services provided to me by **All American OB/GYN**. If applicable, I understand that an insurance card is necessary to validate my coverage for each visit. If I do not have my card with me, I accept financial responsibility for all services provided to me by All American OB/GYN in the event that I am not covered for these services, and I understand that I will receive a bill for these services from All American OB/GYN. Some insurance policies require written referral from my primary care physician for specialist services to be covered. If I do not have a referral, I accept financial responsibility for the services provided by specialists at All American OB/GYN. If I am treated for a procedure or service that is not covered by my insurance, I accept responsibility for all bills created from this visit.

Patient Signature: _____
(Or parent, or legal guardian)

Date: _____