By signing this document, I have fully read and understand the financial policy of Atlanta Women's Health Group. I hereby consent to allow your practice to reach me via: (check all that apply)

- ◯ Home Phone: _____
- ◯ Cell Phone: _____
- ◯ Work Phone: _____
- ◯ Fax: _____
- ◯ Text: _____
- ◯ Email: _____

I will cooperate with the billing department at Atlanta Women's Health Group to ensure payment for my services. I understand that I will be responsible for any cost(s) associate with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to patient herein.

_____

Print Name of patient/parent/guardian

_____ _____

Signature of patient/parent/guardian Date