Jeri Shuster, M.D., P.A.
and Women's Center, Inc.

Jeri Shuster, M.D., Fellow of the American College Obstetricians and Gynecologists
Kathryn Cervi, C.R.N.P., Women's Health Care Nurse Practitioner

ACKNOWLEDGEMENT, AUTHORIZATION AND ASSIGNMENT

As the patient, I acknowledge my responsibility to pay the fees charged for all services rendered, regardless of anticipated insurance coverage. I understand the doctor's office staff will file insurance claim forms when possible as a courtesy to me, the patient. Payment is due at the time health care services are rendered unless prior arrangements are made.

I understand that I will be responsible for obtaining any pre-authorizations and/or referrals, as outlined in my insurance coverage, and will bring them in to this office prior to my procedure.

I authorize the release of any private healthcare information pertaining to me that is necessary to process any insurance claim. I authorize payment of any medical reimbursement benefits payable for services rendered directly to **Jeri Shuster, M.D., P.A.**, EIN 52-1720775, MD License # D34215 and/or to **Jeri Shuster, M.D., Women's Center Inc.**, EIN 52-2011718, and further, I irrevocably assign such benefits to the above named entities.

I acknowledge and agree that I will pay the stated charge of $75 for any missed appointment not cancelled at least 48 hours in advance. All unpaid balances are due in full within 60 days of the date of the invoice. Unpaid balances after the 60 day period are subject to a **monthly interest rate of 1.5%** (equivalent to an annual interest rate of 18%) on the unpaid balance until paid in full.

Further, should any unpaid account result in attorney collection, **I agree to pay all collection and attorney fees equal to 30% of the unpaid balance. If collection action is necessary, I am aware that Dr. Shuster will discharge me from the practice and no longer be my Gynecologist.**

If you believe there is an error in your account, you must notify the doctor's office, **in writing**, within sixty (60) days of the invoice date. You must provide a description of the error, the dollar amount of the error, a statement as to why you believe there is an error, and any information you believe will aid in resolving the error.

______________________________ ______________________________
Patient / Guardian Signature Date

____
Print Name of Patient / Guardian

______________________________ ______________________________
Witness Signature Date

FINANCIAL RESPONSIBILITY GUARANTEE

I guarantee to be financially responsible for any unpaid charges resulting from medical services provided by the doctor. I have read this document and I execute it with full knowledge, understanding and acceptance of its contents.

______________________________ ______________________________
Witness Patient / Guardian Signature

______________________________ ______________________________
Date Print Name of Patient / Guardian

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