Women's Health Center of Dickson, PLLC

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I,_____, have received a copy of Women's Health Center of Dickson, PLLC's Notice of Privacy Practices.

Signature of Patient_____

Signature of Parent or Guardian_____

My Medical information may be released to the following people:_____

_____

Authorization for Insurance

I,_____, authorize release of any medical information or other information necessary to process my insurance claims and assign any medical payment directly to my physician. I understand that some services may not be covered by insurance and I accept full financial responsibility and agree to pay the total amount due or the remainder not paid by insurance. I understand that I am responsible to pay for services rendered and any attorney's fee and cost of collection in the event of default.

Signature_____

Signature of Parent or Guardian_____

Date_____