WOMEN'S WELLNESS COMPREHENSIVE CARE
535 OCEAN AVE SUITE 4
PORTLAND, MAINE 04103

FAILURE TO PROVIDE CURRENT INSURANCE CARD/INFORMATION AT THE TIME OF APPOINTMENT

I understand that at today's appointment I did not provide my current insurance information. I understand that I have 48 hours to provide this information to the billing office or I will be 100% responsible for all charges for today's appointment. I understand that my insurance company may not pay for my visit due to timely filing because of my delay in providing the correct insurance information.

I acknowledge that I will be 100% responsible for the cost of the visit today if I do not provide a copy of the front and back of my insurance card to the billing office.

(Please fax to 207-518-6001 – Attention Billing Office)

The insurance information is due to the billing office by ___/_____/_____, if I do not provide my current insurance information, by the afore mentioned date then I authorize WWCC and Casco Medial Group, LLC to bill me directly for all cost associated with my care and treatment associated with today's appointment.

_____ _____

Signature of Patient or Legal guardian Date of Visit (Updated 4.16.15)