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### REASON FOR TODAY'S VISIT

\_\_\_\_\_ Initial Obstetrical Visit  
\_\_\_\_\_ I **am/am not** having problems that I want addressed today. (circle one)  
\_\_\_\_\_ My complaint is \_\_\_\_\_

\_\_\_\_\_ Routine Preventive Exam (Well Woman)  
\_\_\_\_\_ Procedure: \_\_\_\_\_  
\_\_\_\_\_ Injection:  
\_\_\_\_\_ Gardasil®                      \_\_\_\_\_ Depo Provera                      \_\_\_\_\_ Other \_\_\_\_\_

.....  
**Please initial beside each paragraph below:**

\_\_\_\_\_ A well woman exam, preventive visit includes a medical history, physical exam and testing to screen for asymptomatic diseases and renewal of maintenance medications. SHOULD ANY PROBLEMS/ISSUES OUTSIDE OF A ROUTINE EXAM BE ADDRESSED AT TODAY'S VISIT, THERE MAY BE ADDITIONAL CHARGES, INCLUDING COPAYMENTS AND/OR DEDUCTIBLES AND CO-INSURANCE.

\_\_\_\_\_ I understand that some or all of my charges may be applied to my deductible, co-insurance or even excluded from my policy, and I understand/agree that I will be responsible to pay for these services.

\_\_\_\_\_ I agree to pay for any and all medical services I receive from Women Ob/Gyn, P.A. that are not covered services or if payment is denied by my insurance company, for any reason.

\_\_\_\_\_ To prevent erroneous denials and to assure appropriate insurance reimbursement for your visit, be sure that you clearly indicate above what you are being seen for today. DIAGNOSIS CODES WILL NOT BE CHANGED AFTER THEY HAVE BEEN SUBMITTED TO THE INSURANCE CARRIER.

\_\_\_\_\_ If I fail to pay for services provided by Women Ob/Gyn, P.A. when due, I agree to pay usual billing and late charges, and all costs of collection, including reasonable attorney fees incurred are part of the collection process.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date (MM/DD/YYYY)