Women's Health Center of Clarksville

Dr. Lisa McIntosh, MD & Dr. William McIntosh, MD

Self Pay Agreement Form

Patient Name: _____ Date of Birth: _____/_____/_____

Welcome to the Women's Health Center of Clarksville, where our professional staff are committed to providing you with the highest quality medical services.

The following is a statement of our Self Pay Financial Policy, which we require you to read and sign prior to receiving treatment:

Please be aware as a new patient, you will be charged new patient charges ranging from $80.00 to $281.00. Established patient charges range from $60.00 to $201.00. These charges are prior to a 30% pay in full discount.
*Charges are based on the complexity of your visit.

By signing this authorization, I understand as a self pay patient:
- That I am responsible for paying my account for today's provider visit.
- That in addition to the office visit charges today, there may be additional charges for labs, x-rays, ultrasounds, mammograms, injections, testing, etc.
- That if there are any additional charges, I will receive a statement from the contracted company rendering the services to me, and I agree to pay for any additional charges incurred.

Authorization to Release

I have read and fully understand the Self Pay Financial Form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all additional costs/fees associated with the collection process.

Print name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature if patient is a minor: _____ Date: _____