Patient Name: DOB:

Medicaid Plan/# (if available):

I request to be seen by Drs. Arbona/Chan/CNP Stephanie Beier-Philips at Northside Women's Health. I understand that my doctor and Nurse Practitioner do not participate with any Medicaid plan (i.e. Caresource, Molina, Paramount, Buckeye etc.). I agree that all charges incurred at this office will not be billed to Medicaid, that I am personally and fully responsible for any and all charges and certify that I have been informed in advance that I am responsible for the full payment of any and all charges.

_____ _____

Patient/Responsible Guardian Signature Date

_____

Relationship to Patient