WOMEN'S WELLNESS & GYN SURGERY CENTER

Karen Leung, MD, FACOG
Board Certified Gynecologist

INSURANCE COVERAGE

I, _____, hereby certify that I am eligible for
(Patient Name)

Health Plan coverage with _____as of
(Insurance Company)

_____ through _____.
(Month, Day & Year) **(Employer Group- if applicable)**

I have chosen _____Dr. Leung_____ to be my gynecologist.
(Physician's Name)

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Health Insurance Agreement, I am liable for all charges for the services rendered. If the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Women's Wellness and GYN Surgery Center.

Also, I understand that a determination of coverage of benefits and deductibles is not made until claim for services is presented to the insurance company. Therefore, I agree to pay all charges that include my deductible and any denied benefits within 30 days from receipt of statement from Women's Wellness and GYN Surgery Center.

LABORATORY AND PATHOLOGY SPECIMENS
Blood work, pap smears, and biopsies are sent to be processed or evaluated at pathology or at a laboratory. Their charges are separate from the doctor's fees and are the responsibility of the patient.

_____ _____
Patient's Printed Name (or legal guardian) **Date**

_____
Patient's Signature (or legal guardian)

_____ _____
Office Personnel (Witness) **Date**

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