Life Steps OB/GYN, *Health Care for Women, LLP*
60 EAST END AVENUE, NEW YORK, NY 10028 PHONE (212)860-4800 FAX (212)860-4891

DATE_____

PATIENTS LAST NAME _____PATIENT FIRST NAME_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #:_____/_____/_____

To All Patients of Life Steps OB/GYN, Healthcare for Women, LLP

We appreciate and respect the trust you place in us to provide you with gynecologic and/or obstetric care and services.

Please understand that your benefit plan is an arrangement that involves you, your insurance carrier and your employer. Occasionally, gynecologic, pre-natal, and delivery care that you request from us is not covered by your plan or there is a deductible, co-payment, or co-insurance that you are or we are not aware of at the time of your visit.

In order for our office to run smoothly and continue to offer you high quality care, we respectfully request that you sign below to authorize Life Steps OB/GYN, Healthcare for Women, LLP to keep your signature on file and charge your credit care for the balance of charged not paid or covered by insurance.
You will receive a courtesy call prior to our charging in excess of $250.00

Thank you for your cooperation,

Life Steps OB/GYN, Healthcare for Women, LLP

Card type: (please circle one): ( )VISA ( )Mastercard ( ) AMAX ( ) FLEXCARD

Name on Credit Card/ Flex Card: _____

Credit Card Number: _____

Expiration Date: _____

Security Code :_____

Billing Address: _____
(Street) (City) (State) (Zip)

Please note: Scheduled appointments not canceled by 4pm the prior business day are subject to a $40.00 no show fee. Returned checks are subjected to a $25.00 returned check fee.

_____ _____
Signature Date