809 Cleveland Ave S.W.
Atlanta, GA 30315
404-767-2536 / Voice
www.cwhallc.com

Verification of Insurance Coverage and Referral Waiver

I understand that my insurance coverage through:

_____

has not been verified by Comprehensive Women's Healthcare Atlanta LLC at the time of my appointment, but my signature below verifies that I want to receive medical services from **Dr. Kimberly Carroll.**

I further understand that once my health insurance has been verified with the insurer, the insurer will issue a disclaimer that they do not guarantee payment despite the fact that I may be covered at the time I receive services from Comprehensive Women's Healthcare Atlanta LLC. In the event that I am not covered at the time of service or that the specific services provided are not covered, I understand and agree that I am responsible for payment for all services rendered.

If my insurer requires a Referral from my Primary Care Physician and that Referral is not received prior to the date of my appointment with Dr. Carroll, I agree to pay for all services at the time they are rendered.

Signature: _____

Printed: _____

Patient Name: _____

Date Signed: _____