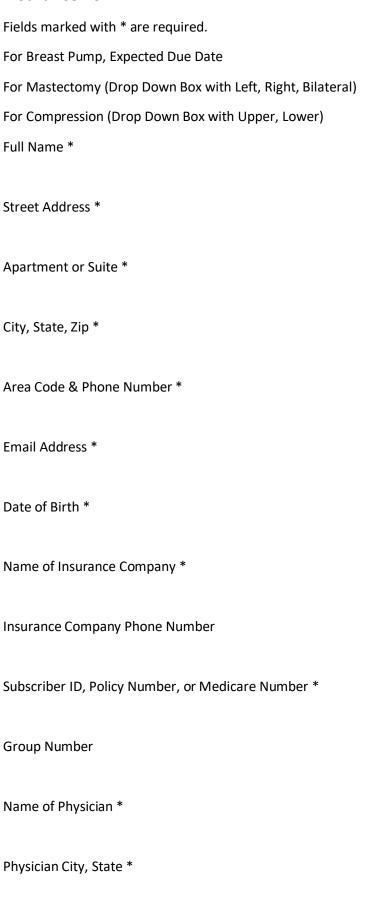
## **Insurance Form**

Physician Phone Number



hold of medical information/Medical Records - By checking the Yes box, I hereby authorize any hold of medical information concerning me to be released to Women's Health Boutique. I also authorize copies of my medical records to be mailed or faxed to Women's Health Boutique upon request, for medical claims to be filed on my behalf to Medicare, Medicaid, and/or Insurance.
Yes
No
*Assignment of Benefits – By checking the Yes box I request the payment of authorized products or services benefits be made on my behalf to Women's Health Boutique for any products or services furnished to me. I understand that Women's Health Boutique assumes unconditional responsibility for refunding any overpayments that are made by my Insurance Carrier.
Yes
No
Send a copy of this message to yourself.
SUBMIT

By submitting this form, you are acknowledging that Women's Health Boutique may be contacting you for any additional information if needed.