OBSTETRIX
MEDICAL GROUP

I, _____ understand and have been
(patient's name)
informed that the following services, all services provided by Obstetrix Medical Group of Houston, may not be covered by my insurance and/or Medicaid and that I am responsible for full payment to Obstetrix Medical Group of Houston for these services provided.

_____
Signature of Patient

_____
Date

_____
Signature of Guardian, if minor

_____
Date

_____
Witness

_____
Date