

West End Ob\Gyn, PC  
7601 Forest Avenue  
Suite 100  
Richmond, Virginia 23229

Re: **Processing of Disability, Leave of Absence Form or Insurance Form:**

Patient Name: \_\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Dr: \_\_\_\_\_

From: \_\_\_\_\_

Patient responsible for Thirty (\$30.00) processing charge fee.

**Method of payment:**

**Practitioner:**

Cash \$ \_\_\_\_\_

Davis\_\_\_\_ Dausch\_\_\_\_ Murray\_\_\_\_

Check# \$ \_\_\_\_\_

Mahoney\_\_\_\_ Jones\_\_\_\_

Charge Card # \_\_\_\_\_ Amount \$ \_\_\_\_\_ Expiration Date \_\_\_\_\_

**THIS IS A MISCELLANEOUS CHARGE THAT WILL NOT BE BILLED TO  
YOUR INSURANCE COMPANY.**

Carolyn McDaniel  
Practice Manager