

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

Re: **Processing of Medical Records**

To: _____ SS# ____ - ____ - ____

Dr: _____

From: _____

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

Method of payment:

Cash \$ _____

Check# \$ _____

Charge Card # _____ Amount \$ _____ Expiration Date _____

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

Carolyn McDaniel
Office Administrator