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

Re: **Processing of Medical Records**

To:_____SS# ___-__-____

Dr:_____

From:_____

Patient responsible for $_____ 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