



INSURANCE AUTHORIZATION AGREEMENT

Initials: _____

I hereby authorize my insurance benefits to be paid directly to Bloom Ob Gyn, LLC and I certify that I am financially responsible for all charges. The information I have reported regarding my insurance coverage is correct. I consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payer, insurer or another health benefit plan. I permit a copy of this authorization to be used in place of the original. I also hereby assign any major medical benefits payable in relationship to services rendered by Bloom Ob Gyn, LLC.

ULTRASOUND WAIVER

Initials: _____

I am choosing to have my ultrasound performed at Bloom OB/GYN. I understand that the charge for this service will be billed to my insurance and that a medically necessary and appropriate ultrasound does not guarantee coverage. I understand that I am financially responsible for these charges. I also understand that when an ultrasound is performed multiple studies may be done during one visit and, therefore, more than one charge may be generated.

NO SHOW POLICY

Initials: _____

Out of respect for other patients and our providers, we kindly request 24-hour notification for cancellation of appointments. Failure to do so will result in a “No Show Fee” of \$50.00 for each visit missed. Additional charges will be assessed for missed procedures.

CODE OF CONDUCT POLICY

Initials: _____

I have reviewed and acknowledge the code of conduct policy, and I agree to adhere to the expectations as outlined by Bloom OB/GYN. I am aware that failure to adhere to this policy may result in discharge from the practice.

ANNUAL FEE FOR NON-COVERED SERVICES

Initials: _____

I understand that this fee is paid on an annual basis and that it applies to non-covered services or those services that are not paid for by insurance. This fee is discounted for students with a non-expired and valid student identification card.

I certify that I have read and understand the foregoing.

Patient Name: _____

Date: _____

Signature: _____