BLOOM OB/GYN

Authorization Agreement

I hereby authorize my insurance benefits to be paid directly to Bloom Ob/Gyn, LLC and I am financially responsible for all charges.

I certify that the information I have reported with regard to 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.

I certify that I have read and understand the foregoing.

Patient Name: _____

Signature

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____