BLOOM
OB/GYN

INSURANCE AUTHORIZATION AGREEMENT **Initials: _____**

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.

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, but that this is not a guarantee of coverage. I also understand that when an ultrasound is performed multiple procedures may be done during one visit and more than one charge may be generated. Additional procedures may be performed according to each clinical situation. It may also be necessary to perform an internal ultrasound to properly assess a clinical concern and this cannot always be determined at the time the ultrasound is ordered. A medically necessary and appropriate ultrasound does not guarantee insurance coverage.

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. Additional charges will be assessed for missed procedures.

I certify that I have read and understand the foregoing.

Patient Name: _____

Date: _____

Signature: _____