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.

TELEMEDICINE POLICY **Initials: _____**

I understand that my healthcare provider may offer me a Telemedicine appointment. This appointment type allows the convenience of interactive video conferencing in lieu of an in-office visit. I understand that a Telemedicine visit will be billed to my insurance as if I had been seen in the office and that a co-payment may apply, as determined by my insurance plan. 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, including a co-payment if applicable.

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: _____