

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize any member of the Atlantic Obstetrics & Gynecology practice or their designees to provide medical treatment. I hereby authorize release of information pertaining to/for insurance purposes and authorize Atlantic Obstetrics and Gynecology to receive direct insurance payments for professional treatment otherwise payable to me for services rendered. I understand that I am financially responsible for payment of all services at the time they are rendered, unless other payment arrangements have been established. The undersigned agrees to be responsible for court costs and 33 and 1/3 attorneys fees associated with the collection procedures brought by Atlantic Obstetrics and Gynecology, should that be necessary.

Due to the high volume of disability forms, the office requires seven (7) business days to complete your forms including FMLA paperwork. Also, there will be a fee of \$20 for this service which we require to be prepaid.

Please provide a 24 hour notice of any appointment changes. There will be a charge of \$25.00 to patients who “no-show” for their appointment.

PATIENT SIGNATURE

WITNESS SIGNATURE

DATE