

Assignment of Benefits & Release Authorization

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Preferred Gynecology for medical or surgical services or items rendered to me or my dependent by Preferred Gynecology. Should my insurance carrier deny Preferred Gynecology payment, I understand that I am financially responsible for the charges. I authorize Preferred Gynecology to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

PATIENT
SIGNATURE _____ DATE _____

PRINT
NAME _____ D.O.B. _____

PARENT OR LEGAL
GUARDIAN _____ DATE _____