AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT

_____ , hereby authorize *Adler Gynecology Minimally Invasive Surgery* to apply for benefits on my behalf for services rendered by *Adler Gynecology Minimally Invasive Surgery*.

I request payment from_____ to be made directly to *Adler Gynecology Minimally Invasive Surgery*. (INSURANCE COMPANY NAME)

I certify that the information reported herein is correct and further authorize the release of any necessary information including medical information for this or any other related claim from the billing agent for Adler Gynecology Minimally Invasive Surgery to the above named insurance company as deemed necessary or as requested by the insurance company without notice.

I also permit a copy of this release to be used in place of the original.

I also realize that insurance is not a form of payment and all charges are my responsibility, with payment due in full at 90 days. I also understand that any changes in the above insurance information are to be reported by me within 10 workdays from the new effective date. Failure to do so, releases *Adler Gynecology Minimally Invasive Surgery* and/or his agents from our billing agreement and payment becomes due at the date of service.

In the event that my account is placed in the hands of any collection agency, I agree to pay all costs and expenses, including attorney's fee related to the collection thereof.

Signature: _____ Date: _____

(PATIENT'S SIGNATURE)

Patient Information Re verification:

Office Initials	Date	Patient Initials	Date
Office Initials	Date	Patient Initials	Date
Office Initials	Date	Patient Initials	Date

I have received the HIPPA Notice of Privacy Practices and the Financial Polity for Adler Gynecology Minimally Invasive Surgery.

Signature_____Date_____