

**ATLANTA MIDTOWN GYNECOLOGY, INC**

**INSURANCE VERIFICATION**

Under new federal regulations, our office is now required to verify your demographic information with your insurance company.

If the information that we have on file does not match the information your insurance company has on file, our office can not obtain vital information to have claims paid and procedures scheduled.

Therefore, it is your responsibility to ensure that your insurance company has the correct information on file for you and that you keep your insurance company and your doctor's office informed of any changes in address or telephone number.

If our office is unable to verify information with your insurance company, it may result in procedures being delayed and claims not being paid.

In the case we are unable to contact you to inform you of the situation, you will be held responsible for any outstanding claims on your account.

**ASSIGNMENT OF BENEFIT / CONSENT FOR TREATMENT**

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to Atlanta Midtown Gynecology INC. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I understand that I am responsible for all applicable interest or service charges, and/or collection costs associated with collecting the debt, including reasonable attorney's fees due to default in payment. I hereby voluntarily consent to my treatment at Atlanta Midtown Gynecology INC and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me, the patient, concerning the results which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

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Patient Name or Guardian Name

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Patient Signature or Guardian Signature

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Date