SARAH DUTTA, MD

OBSTETRICS, GYNECOLOGY, INFERTILITY • BOARD CERTIFIED

AUTHORIZATION/RELEASE/AGREEMENT

Patient: ____ Date of Birth: __________________

Authorization for Medical Treatment: I authorize Sarah Dutta, Ob-Gyn, S.C. and employees to provide medical, surgical and hospital services to me including diagnostic tests and therapeutic procedures necessary for the diagnosis and treatment of my illness or condition. I further authorized medical care, testing and treatment as necessary in emergency situations to preserve my life and health and to protect the health of persons involved in my care without first obtaining consent from me or my family.

Release of Information for Billing: I authorize release to insurance companies and their administering entities, governmental agencies or their intermediaries, third party payers providing benefits to me, and to third party collectors, copies of all medical records or other information necessary to determine available benefits and to obtain payment for services rendered to me during all courses of treatment. I understand that: my medical records may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information, and I authorize release of such medical records for the purpose of billing and collections; I have the right to inspect and obtain a copy of information disclosed; this is authorization is valid until the date of one year following today's date; I have the right to revoke this authorization at any time, except to the extent that actions were taken in reliance thereon; and if I refuse to sign or revoke this authorization Sarah Dutta, Ob-Gyn, S. C. may not be able to release medical information necessary to process claims for insurance benefits, I will be billed directly for these services.

Assignment of Benefits: I assign to Sarah Dutta, Ob-Gyn, S.C. all claims and rights to payment under any insurance policy or health plan of which Patient is beneficiary, and consent to whatever legal action Sarah Dutta, Ob-Gyn, S.C. and its agents deem appropriate to obtain payment. Authorization is given for the application of any overpayment on any unpaid bill with Sarah Dutta, Ob-Gyn, S. C. for any other patients for which the undersigned is responsible that has not been paid in full at the time of the overpayment.

Agreement to Pay: I understand that the patient/guarantor is responsible for all the charges incurred and residual balances including, but not limited to copays, deductibles, co-insurance and charges not paid by the insurance carrier for any reason, after consideration of contractual adjustments. ***I agree to remit payment in full for all services and supplies provided to me and my dependents within 30 days from the date of the first billing.*** Questions regarding insurance coverage and benefit levels should be directed to your health care plan and the certificate of coverage. ***I agree to pay all costs incurred in the collection of my payment obligation to Sarah Dutta, Ob-Gyn, S.C. including 50% collection agency fees, attorney's fees and costs of suit.***

Personal Valuables: I agree the Sarah Dutta, Ob-Gyn, S.C. is not liable for loss, theft, damage or destruction of any personal property on the premises, including money, jewelry, etc.
This agreement is effective as of the date of my signature and applies to all services provided. If the undersigned is not the patient. I have read and fully understand this Agreement.

____ ____________________________

Signature and Relationship Date

Staff Intials_____