Downriver Obstetrics & Gynecology, P.L.C.

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AUTHORIZATION/RESPONSIBILITY AGREEMENT

I have requested that Downriver Obstetrics and Gynecology bill my insurance company for covered services on my behalf. I clearly understand that it is still my responsibility to make sure that my bill is paid in a reasonable time. If, for any reason, any portion of my bill is not paid by my insurance company, I hereby agree to pay promptly. I understand that I am responsible to pay all co-payments and deductibles under my insurance plan at the time of service. I will promptly pay for all services not authorized by my insurance company.

I hereby authorize any insurance company to pay the proceeds of any of my benefits due me directly to Downriver Obstetrics and Gynecology. A copy of this agreement shall be considered an original for insurance purposes.

I understand that in the future, I may request that copies of my medical record be sent to other physicians, providers, or even myself. I further understand that there will be a charge associated with any medical records release in order to cover the cost of reproducing the medical record.

In order to process a claim for benefits, I further authorize Downriver Obstetrics and Gynecology to release any appropriate information regarding my medical history, symptoms, treatment, and examination results and diagnosis in order to expedite payment from my insurance carrier. A photocopy of this original authorization shall be considered effective and valid.

Patient's Signature:_____ Date:_____