LIFESPRINGS
WOMEN'S HEALTHCARE
Jennifer Anderson Maddron, M.D.

INSURANCE AUTHORIZATION & ASSIGNMENT / PAYMENT AGREEMENT

For:_____ DOB: _____

Insurance: _____ ID#: _____

Insurance: _____ ID#: _____

Insurance: _____ ID#: _____

The patient is always responsible for HER ACCOUNT BALANCE, regardless of insurance coverage or how much insurance company elects to pay. Insurance rarely covers all of the fees incurred. Your insurance is an arrangement between you and your carrier, not between this office and the carrier.

1. I hereby authorize the release of any medical information necessary to process my insurance claim(s).
2. I hereby assign, transfer, and set over to LifeSprings Women's Healthcare, LLC and its providers all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above name insurance company (ies).
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked in writing by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I understand that my bill is due and payable upon receipt.
6. I will be responsible for any and all fees to the collection of my bill should it be necessary to refer my bill to collections.

SELF PAY PATIENTS

1. If you are applying for insurance coverage or changing benefits it is critical that you inform us and keep us informed of the progress that you are making. Unfortunately, until we receive confirmation of your active coverage we will have to consider your account as a self-pay account and we will expect payment at the time of service.
2. Payment plans are available in many instances but you are expected to comply with the arrangements that are set up for you. It is critical that you keep us informed if there is a problem in making the arranged payment schedule. Our staff will work with you and we do not currently charge interest on our payment plans.

_____ _____

Signed (Patient or Representative) Date