

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I hereby assign payment directly to The OB/Gyn Place, A Medical Corporation and Prema Kothandaraman, M.D., for the Obstetrical Care, Surgical, medical or major medical benefits if any, otherwise payable to me for services as reported.

DATE \_\_\_\_\_

\_\_\_\_\_  
Signature (Insured)

**PAYMENT OBLIGATIONS**

I understand that my insurance company will be billed directly for the services received from the OB/Gyn Place, A Medical Corporation and Dr. Prema Kothandaraman. After 30 days from the date of service, it is my responsibility to follow up with my insurance company on any unpaid bills. After this period, I will be responsible for the payment in full.

DATE \_\_\_\_\_

\_\_\_\_\_  
Signature (Insured)

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize The OB/Gyn Place, A Medical Corporation and Prema Kothandaraman M.D., to release any information acquired during my examination or treatment only to: Insurance Companies, other physicians that might require additional information for my medical care.

DATE \_\_\_\_\_

\_\_\_\_\_  
Signature (Patient or guardian if a minor)

**HIPAA PRIVACY ACT**

I have seen and have been offered a copy of this office's notice of the HIPAA Privacy Act.

DATE \_\_\_\_\_

\_\_\_\_\_  
Signature (Patient or guardian if a minor)