Atlanta Perinatal Associates
www.atlantaperinatal.com

RELEASE OF INFORMATION

This office will file insurance claims as a courtesy to the patient. However, payment in full is expected when services are rendered. It is further understood that certification of insurance benefits is not a guarantee of payment by the carrier.

I hereby authorize Atlanta Perinatal Associates and/or its staff to release medical information to insurance companies concerning the patient's illness and treatment. I hereby assign the Physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for any and all amounts not covered by my insurance carrier. Please note there is an out of pocket fee of $25 for the completion of all disability forms.

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed and had an opportunity to ask questions concerning Atlanta Perinatal Associates Notice of Privacy Practices. Upon request, I have the right to obtain a copy of these noted practices at any time during the course of my treatment.

INFORMED CONSENT FOR DISCUSSION OF MEDICAL AND PERSONAL INFORMATION

Please understand that you have been referred to Atlanta Perinatal Associates for a diagnostic ultrasound. Upon entrance to the exam room, it is possible that an open discussion of your personal and/or medical history will ensue. If you have a guest with you that you do not want your personal information discussed in front of, we ask that you please have them wait in the lobby until your exam is completed. This will protect your right to privacy and help us to better service you. We ask that you sign below stating that you understand and agree to these terms.

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□ I do hereby consent to having all medical and personal information discussed with me and my guest

□ I do not want my medical and personal information discussed with anyone other than myself and opt to have my guest absent from the exam room

Signature Date