



I hereby authorize Obstetrics & Gynecology Associates, Inc. to SUBMIT CLAIMS to my health insurance company for all covered services rendered by Obstetrics & Gynecology Associates, Inc. and direct the health insurance company to issue payment directly to Obstetrics & Gynecology Associates, Inc.

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Signature of Subscriber

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Date

I authorize the physician signing this report to furnish complete information to my health insurance company regarding services rendered and I hereby assume responsibility for any charges not covered by my health insurance.

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Signature of Patient

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Date