Patient Name: ____ Chart#:________________

(First) (Maiden or Middle Initial) (Last)

ASSIGNMENT OF BENEFITS AUTHORIZATION

I hereby authorize Columbus ObGyn Specialty Center to furnish information to insurance carriers concerning my illness and treatments, including office/progress notes, surgical reports, laboratory and pathology results, and any other information necessary to process claims filed. I hereby assign to the provider(s) all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance if assignment was taken.

____ ________________

Signature of Patient or Guardian/Parent (if a minor) Date

NONDISCRIMINATION POLICY

Columbus ObGyn Specialty Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment.

COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY (LEP) AND FOR PERSONS WITH IMPAIRED HEARING, VISION, OR SPEECH

Columbus ObGyn Specialty Center will provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons and to persons with impaired hearing, vision, or speech, who wish to be patients here at our practice. If any of these resources are needed, please notify our office PRIOR to the day of your appointment so that arrangements can be made. Our contact number is 662-240-0095.

____ ________________

Signature of Patient or Guardian/Parent (if a minor) Date