Connor's Healthcare for Women
1181 Hutto Road
Orangeburg, SC 29118

** Claims Authorization**

I request that payment of authorized Medicare, Blue Cross, Medicaid or Private Insurance benefits be made on my behalf to this office for any services rendered to me by Connor's Healthcare for Women. I authorize any holder of medical information about me to be released to Connor's Healthcare for Women and its agents, DSS, or Private Insurance Carrier to determine benefits payable for services rendered.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of insurance coverage including a reasonable time thereafter, until it final consummation.

I understand that I am financially responsible for all charges, including deductibles, co-pays and non-covered services not paid by the specified insurance at the time services are rendered. I further understand I am financially responsible for all attorney fees or legal fees required to collect any balance due by me. I permit a photo copy of this authorization as valid as the original.

** Failure to Make Payment**

I understand that I am financially responsible for all services rendered. I will be billed for any payments that are not covered. I understand that I may be refused a routine appointment if I consistently do not make payments on a previous or current balance.

Returned Check Fee

I understand that I will be charged a service fee for all returned checks written for payment on my account. I further understand I will be required to replace the bad check, pay the service charge and all other fees accrued by Connor's Healthcare for Women in cash or money order within 10 days after notification.

I verify I have read and agree to the above authorization.

Signature: _____ *Date:* _____
(Patient or Guardian)