
I understand if I have an ultrasound at Gallatin Women's Center, it is performed by The Perinatal Group.

**AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize The Perinatal Group to release any medical information necessary to process my claim to: 1) my insurance carrier or its designated representatives. 2) Person(s) financially responsible for my care or treatment in order to obtain payment for expense incurred.

**ASSINGMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

The Perinatal Group is happy to assist you in submitting and appealing your claims. Please understand that your insurance policy is an agreement between you and your insurance carrier. You are responsible for deductibles, co-payment, or percentage portions required by your policy. If your account is turned over to collection, there will be a 30% increase to your balance.

My signature, or that of my representative, confirms my understanding of the above.

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Signature of Patient or Authorized Representative Date