



HEALTHCARE MEDIATION LLC

Phone Number: 800-837-1627

Fax form to: 888-701-9463

Email form to: access1@hcmediation.com

Mail form to: 14900 Avery Ranch Blvd
Suite C-200 #41
Austin, TX 78717

Agreement to Perform HealthCare Mediation and Negotiation

I authorize HealthCare Mediation, LLC to negotiate rates with provider(s) as referred by me.

I authorize HealthCare Mediation, LLC to negotiate referred bills with the intention to obtain a discount of fees for services rendered.

HealthCare Mediation, LLC makes no claims as to the competency and/or qualifications of the provider(s).

By signing this agreement, I hold HealthCare Mediation, LLC and all of its employees, officers, and contractors, of any and all liability with respect to services rendered by the provider(s).

Any dispute between HealthCare Mediation, LLC and I that cannot be resolved, will be resolved with a mutually acceptable mediator.

HealthCare Mediation, LLC's fee for the services provided is (twenty-five percent) 25% of the savings negotiated. I agree to pay the provider in the time specified by the provider and I agree to pay HealthCare Mediation, LLC for its services rendered upon receipt and acceptance of the documentation of savings.

I certify that I am the patient or responsible party for the patient receiving services rendered by the provider(s) and I have executed a HIPAA Authorization to Release Information in conjunction with the services provided by HealthCare Mediation, LLC

Member

Member

Patient Name

Responsible Party

Signature of Responsible Party

Date

Documentation of Discount(s) & Agreement(s) to Pay Attached

Access One

Referred by



Phone Number: 800-837-1627

Fax form to: 888-701-9463

Email form to: access1@hcmediation.com

Mail form to: 14900 Avery Ranch Blvd
Suite C-200 #41
Austin, TX 78717

Authorization for Release of Information

I hear-by authorize the use or disclosure of my individual identifiable health information as described below to HealthCare Mediation, LLC.

I understand by signing this release I give HealthCare Mediation, LLC the authority to act in my name and place to accept, receive, discuss and process information in your possession about my medical bills. This includes, but is not limited to, medical records, medical bills and all of my other medical records.

I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that I may revoke it at any time by submitting my revocation in writing at in time to the entity providing the information.

I authorize HealthCare Mediation, LLC to process, discuss, receive and accept information for any medical bill or charge incurred on my behalf.

I authorize HealthCare Mediation, LLC to have the authority to make financial arrangements on my behalf.

Patient Name (printed): _____ Date of Birth: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

Email Address: _____

Authorized Signature: _____ Date: ____/____/____
