Email Forms To: claims@hcmediation.com
Phone Number: (888) 719-9463
Fax Form To: (888) 701-9463
Mail Form To: HealthCare Mediation LLC
14900 Avery Ranch BLVD
Suite C-200 #41
Austin, TX 78717

Date: ______________________

Agreement to Perform Medical Bill 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 (thirty percent) 30% 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

______________________ ______________________

Patient Name | Responsible Party

______________________ ______________________

Signature of Responsible Party | Date

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Who Referred You To Us? / How Did You Find Us?

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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 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 the patient. This includes, but is not limited to, medical records, medical bills and all other patient records.

- I understand that this authorization is voluntary and I may refuse to sign this authorization. If I do refuse to sign this authorization, HealthCare Mediation, LLC will not be able to service my account.

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

- I authorize HealthCare Mediation, LLC to process, discuss, receive and accept information for any claim the Patient is involved with.

- I authorize HealthCare Mediation, LLC to have the authority to make financial determinations on our behalf.

Patient Name (Printed): ______________________________ Date of Birth: ____________

Street Address: ____

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City: ______________________ State: __________ Zip: ______________

Phone Number: ______________________ Fax Number: ______________________

Email Address: ____

Authorized Signature: ______________________________ Date: ____________