



specialists in gastroenterology

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS, AUTHORIZATION TO RELEASE INFORMATION, FINANCIAL POLICY,
CANCELLATION POLICY AND PROCEDURE PROVIDERS

Patient Name: _____

DOB: _____

I. RELEASE OF INFORMATION I, the above named patient, do hereby authorize any physician examining and/or treating me to release information concerning my care to any third party (such as an insurance company, managed care company or governmental agency, example: Medicare or Anthem Blue Cross Blue Shield) any medical condition, psychiatric condition, alcohol or drug related condition and record concerning diagnosis treatment when requested by such third party for it's use in connection with determining a claim for payment for such treatment and/or diagnosis. All releases will conform to the requirements established by the Health Insurance Portability and Accountability Act (HIPAA).

II. PHYSICIAN INSURANCE ASSIGNMENT I, the above named subscriber, hereby authorize payment directly to any physician examining and/or treating me of any group for any services furnished me.

III. LIFETIME MEDICARE AUTHORIZATION I request that payment of authorized Medicare benefits be made to Specialists in Gastroenterology, for any services furnished me by the physicians of the group practice. I authorize any holder of medical or other information about me release to the Social Security Administration and Heath Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

IV. LIFETIME MEDIGAP AUTHORIZATION (SECONDARY POLICY TO MEDICARE) I request that payment of authorized Medigap benefits be made to me or on my behalf to Specialists in Gastroenterology for services furnished to me by the physicians of the group practice. I authorize any holder of medical information about me to release to my secondary insurance any information needed to determine these benefits or the benefits payable for related services.

V. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

VI. FINANCIAL POLICY I understand and agree that health insurance policies are arrangements between ME AND MY INSURANCE CARRIER. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other deductible amount or any other balance not paid for by my insurance. If I default in payment I understand that I will be responsible for any collection and/or legal fees.

VII. CANCELLATION POLICY I understand that I will be charged for ANY missed scheduled office appointments and ANY scheduled office appointments canceled with less than a 24 hour notice. I understand that I will be charged for missed procedures and procedures canceled with less than a 48 hour notice.

VIII. PROCEDURE PROVIDERS I understand that if I am scheduled for a procedure I could receive 3-4 separate bills due to multiple providers of service. There could be a doctor charge, facility charge, anesthesia charge and lab or pathology charge for any biopsy or polyp removal.

IX. LETTER AND FORMS I understand that I may be charged for special letters or forms (FMLA, disability etc). The fee will need to be paid prior to the office completing the forms.

Patient's Signature

Date

Subscriber's Signature (if different than patient)

Date