STATEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that **Gastroenterology Associates, P.A.** may bill my insurance as a courtesy to me, but the financial responsibility for any and all charges incurred during my treatment is mine. In consideration of the services rendered, I promise to pay **Gastroenterology Associates, P.A.** the full amount of charges for said services upon demand or in accordance with payment arrangements agreed by them. I consent to permit **Gastroenterology Associates, P.A.** as with other institutions that extend credit, to access my credit report through a national credit reporting agency, and to use this information in determining the method, timing, and amount of any payments. If I fail to keep this promise, I understand that I will also be responsible for paying the costs of collection.

I understand that if I do not pay the patient due balance in a timely manner and must be sent to a collection agency, that thirty five percent of my outstanding balance will be added to the amount due to cover the costs of collections. I agree to pay this cost in addition to the outstanding balance for services rendered.

Failure to cancel at least 24 hours in advance or no showing for your appointment may lead to an administrative fee.

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SIGNATURE OF PATIENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE DATE

ASSIGNMENT OF INSURANCE BENEFITS

PATIENTS
NAME: ____ DATE: ________________

I hereby request that any and all benefits otherwise due me for services rendered by **Gastroenterology Associates, P.A.** be assigned and paid to **Gastroenterology Associates, P.A.**

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INSURED PERSON'S SIGNATURE

ASSIGNMENT OF MEDICARE BENEFITS

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MEDICARE NUMBER

I request that payment of Medicare benefits for services rendered to me by **Gastroenterology Associates, P.A.** be made directly to **Gastroenterology Associates, P.A.**

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SIGNATURE

Gastroenterology Associates, P.A. Medicare signature on file

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information may be used and disclosed by **Gastroenterology Associates, P.A.** to carry out treatment, payment and health care operations. Please see **Gastroenterology Associates, P.A.'s** Notice about uses and disclosures of information described in this Consent. You have the right to review the Notice before signing this Consent. I consent to **Gastroenterology Associates, P.A.** to release protected health information of:

PATIENT: ____ DATE OF BIRTH: ________________

I understand that signing this Consent authorizes **Gastroenterology Associates, P.A.** to release protected health information including but not limited to, any information acquired over the course of my examination and/or treatment and any information needed to determine benefits or benefits payable for related services to: (1) my insurance company; (2) Centers for Medicare and Medicaid Services ("CMS" formerly known as "HCFA"); or (3) any healthcare provider in the furtherance of my treatment. I understand **Gastroenterology Associates, P.A.** may refuse treatment or may refuse further treatment if I do not sign this Consent or if I revoke this Consent. I understand that I may revoke this Consent at any time, in writing, but my revocation will not be effective as to any consent **Gastroenterology Associates, P.A.** has relied upon. I understand that I have the right to request restrictions on **Gastroenterology Associates, P.A.'s** uses and disclosures of protected health information, even through **Gastroenterology Associates, P.A.** does not necessarily have to agree to my requested restrictions.

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SIGNATURE OF PATIENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE DATE