PATIENT AUTHORIZATION

I hereby authorize Center for Advanced GI Physicians to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including if requested by the above named insurance company. I permit a copy of the authorization to be used in such instances. By signing below, I agree to pay all charges for services rendered by Center for Advanced GI which are not covered by the referenced insurance coverage. If it becomes necessary for Center for Advanced GI to seek judicial action to enforce the above agreement, I agree to pay collection fees and all attorneys' fees of Center for Advanced GI for such action.

REFERRALS

I understand that I am responsible for obtaining a valid referral form from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that Center for Advanced GI will obtain pre-certification as a courtesy for me. I understand that Center for Advanced GI is NOT obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure that any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with Center for Advanced GI that a pre-certification has been obtained for me. I understand in the event a pre-certification is not obtained by me, I will be responsible for any amount not paid, reduced, or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to pay all charges when billed for medical services rendered. As a parent or guardian, I agree to accept legal responsibility for all charges incurred by the patient named. Overdue accounts are subject to a 1.5% interest charge from the date of determination. Appointments not cancelled 24–48 hours prior are subject to a charge. Center for Advanced GI accepts cash, checks, credit card, and money order payments.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize Center for Advanced GI to release my medical information as I have directed. I understand that Center for Advanced GI copy records and that such copying services are subject to a copying charge. I also understand that records must be requested at least one week in advance of desired receipt date. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability, physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by our group.

I authorize my physician to obtain my medication history from my pharmacy or primary care physician.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Center for Advanced GI are committed to privacy and confidentiality. Therefore you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home work. If we need to contact you, may we have your permission to leave a message in regard to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

I AUTHORIZE/REQUEST CENTER FOR ADVANCED GI TO LEAVE A MSSG AT HOME **YES** **NO**

I AUTHORIZE/REQUEST CENTER FOR ADVANCED GI TO COPY MY PHOTO ID **YES** **NO**

PATIENT/GUARDIAN SIGNATURE **DATE**

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____, understand that as part of my health care, Center for Advanced GI originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans of future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare options

I understand that Center for Advanced GI is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.56 of the Code of Federal Regulations.

I further understand that Center for Advanced GI reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.506 of the Code of Federal Regulations. Should Center for Advanced GI change their notice, they will send a copy of any revised notice to the address I have provided (whether US Mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

____ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

OFFICE USE

____ Consent received by: ________________________ on _______________.

____ Consent refused by patient, and treatment refused as permitted.

____ Consent added to the patient's medical record on ____________________.