DIGESTIVE AND LIVER SPECIALISTS
PATIENT FINANCIAL RESPONSIBILITY AND AUTHORIZATIONS

1. I understand that Digestive and Liver Specialists will collect any co-pay, co-insurance, deductible, and outstanding balance due at the time of patient check-in. If a patient is a self-pay patient, payment in full will be collected at checkout. If a patient's insurance company requires a referral in order to see our physicians, it is the patient's responsibility to obtain the referral prior to their appointment with Digestive and Liver Specialists. If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at time of service.

I understand that Digestive and Liver Specialists will file a claim on my behalf to my insurance company. I realize this is done as a courtesy to patients. Regardless of my insurance companies response, I acknowledge that I am responsible for payment in full for services received. My insurance is a contract between my employer, the insurance company and me. Digestive and Liver Specialists is not part of the contract. A COPY OF OUR FULL FINANCIAL POLICY MAY BE REQUESTED AND/OR VIEWED IN THE OFFICE.

X_____ _____ _____

Responsible Person's Signature **Relationship to Patient** **Date**

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2. DISCLOSURE AND ANSWERING MACHINE AUTHORIZATION:

My Primary Telephone Number at which I prefer to receive any telephone call is _____

Telephone Number

_____ Yes, I approve a message being left on a machine

_____ No, I do not approve a message being left on a machine

Alternative telephone numbers (if any) Example: work or cell #

_____ _____

Telephone Number **Telephone Number**

If I am unable to receive information regarding my health, I authorize Digestive and Liver Specialists to disclose any and all information regarding my health information to:

_____ _____

Name of Person to Whom Information May Be Released **Telephone Number**

X_____ _____

Signature of Patient or Patient's Representative **Date**

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3. AUTHORIZATION OF RECEIPT OF PRIVACY PRACTICES:

Digestive and Liver Specialists reserves the right to modify the privacy practices outlined in their notice. I have had the opportunity to read this notice either on the web site (www.gidocs.com) or in the office.

X_____ _____

Signature of Patient or Patient's Representative **Date**

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4. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, which are otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

X_____ _____

Signature of Patient or Patient's Representative **Date**

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5. AUTHORIZATION TO RELEASE HEALTH INFORMATION:

I authorize Digestive and Liver Specialists to release medical information acquired in the course of my treatment which is necessary to process insurance claims.

X_____ _____

Signature of Patient or Patient's Representative **Date**