PATIENT RECORD OF DISCLOSURES

HIPAA INFORMATION: NOTE: You are entitled to receive a paper copy of the HIPAA notice at any time

☐ **YES** I wish to receive HIPAA Notice of Privacy Practice ☐ **NO** Decline receipt of HIPAA Privacy Notice

PATIENT RIGHTS & RESPONSIBILITIES: NOTE: Physician Ownership Disclosure is noted in this documant and is also posted in the patient admit area.

☐ **YES** I wish to receive a copy of Patient Rights ☐ **NO** Decline receipt of this document

I authorize the Center staff to contact me in the following manner.
The communication may contain the following: Personal health information, appointment confirmation, lab results, follow up calls and billing inquiries. (check all that applies)

- ☐ Home/Cell telephone: ____________________
- ☐ Work telephone __________________________
- ☐ Written communication to home address

PERSONAL VALUABLES: I understand that the facility assumes no responsibility for patient's valuables and shall not be liable for loss or damage to personal property.

ASSIGNMENT OF BENEFITS

FOR SERVICES RENDERED YOU WILL RECEIVE A BILL FROM THE FOLLOWING:

1) THE FACILITY 2) PHYSICIAN PERFORMING PROCEDURE 3) PATHOLOGY LAB - IF A SPECIMEN IS TAKEN.

I hereby appoint as my designated authorized representative, and assign to above-named facility all my rights, title and interest in and to, and relating in and to recovery of, any and all health care and/or surgical benefits otherwise payable to me or to which I am entitled for medical treatment, including major medical, rendered by provider. I also specifically authorize my authorized representative to do the following on my behalf:

1) File and prosecute any required appeal or grievance with my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative including filing litigation or arbitration on my behalf and on behalf of my designated authorized representative.
2) File any required complaint, appeal or grievance with the state insurance department, Department of Labor or any other regulatory agency for payment of medical claims submitted by or on behalf of my authorized representative.
3) Discuss my personal health information with my health plan and/or health insurer, and obtain a summary plan description, insurance policy and/or other plan documents.

I hereby authorize direct payment to the Digestive Care Center of any insurance benefit to which I am entitled for treatment services rendered by the Center, but not to exceed the amount of my indebtedness to the Center.

FINANCIAL AGREEMENT AND RESPONSIBILITY

If you would like the Center to bill your insurance provider, you must provide us with a copy of your insurance card(s), proof of identity at the time of admission. Digestive Care Center **does not assume responsibility** for verification of insurance and coverage. I understand that verification of insurance is not a guarantee of payment and that it is my responsibility to contact my insurance company to guarantee payment has been made to the center. All professional services rendered are charged to the patient. I further understand and agree, either as a patient or as the patient's agent that I am financially responsible to the Digestive Care Center for services being rendered to me today. This applies to any out of pocket responsibility such as copay's deductibles, co-ins or non-payment from the insurance company. If I receive payments from my insurance carrier(s) for my services rendered, I will forward the payment immediately to the Center. In the event of non-payment, I agree to bear the cost of collection and / or court costs and reasonable legal fees if required. I also understand that a 12% annual interest will accrue from the date the account goes into collection process due to non-payment. I understand that there will be a $50.00 fee placed on every returned check.

PATIENT OUT OF POCKET RESPONSIBILITIES WILL BE DUE AT TIME OF SERVICE.

______________________________ ______________________________

Patient Signature/Parent/Guardian/Conservator **Date and Time**