

THIS FORM MUST BE RETURNED PRIOR TO ANY PROCEDURES.

GENERAL CONSENT / FINANCIAL AGREEMENT

Patient Name _____ Date of Birth _____

Payment Guarantee / Assignment of Benefits

Initial _____

In consideration of services delivered by Gastroenterology Associates (GA), the undersigned understands, agrees and guarantees the following:

1. To make payment in full on the account.
2. It is their responsibility to obtain any prior authorization(s) deemed necessary.
3. Payment for out-of-network charges is also their responsibility.
4. If any amount due GA becomes delinquent they are responsible for any and all expenses including reasonable attorney fees incurred in collecting this amount.
5. If services are provided to a child the undersigned will be responsible for payment under these same terms.
6. To assign GA all medical benefits payable under an insurance carrier or other responsible party on their behalf.

Release of Medical Records Information

Initial _____

I authorize the release of medical record information to those parties that have agreed to maintain the confidentiality of such information pursuant to applicable law. This authorization extends to records relating to communicable diseases, drug and alcohol abuse treatment records protected by 42C.F.R. Part 2, and mental health records. I understand this consent to release medical record information may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on the consent.

I agree for GA to disclose any health information with regard to my care and treatment to the following *individuals/family members*:

Initial _____

<u>Name</u>	<u>Phone #</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree to have GA physician and staff leave appointments, simple results and instructions on my home answering machine, voice mail, cell phone or work phone.

Initial _____

Financial Disclosure **SIGNATURE REQUIRED BY THE STATE OF INDIANA**

Initial _____

The physicians of Gastroenterology Associates, Inc. have a financial interest in the Indianapolis Endoscopy Center. If you require an outpatient procedure while you are a patient of Gastroenterology Associates, Inc., you may choose to be referred to a healthcare entity other than the Indianapolis Endoscopy Center.

Notice of Privacy Practices

Initial _____

I have received Gastroenterology Associates' Notice of Privacy Practices.

Signature of Patient / Legal Representative

Date

—

Print Name (person responsible for payment) if different from above.