DIGESTIVE DISEASE ASSOCIATES

Patient Name (please print):_____ **DOB:** ____/____/____

Name of Insurance(s):_____

Subscriber, if other than patient:_____ **Relation:**_____ **Date of Birth:**_____ **SS#:**_____

FINANCIAL POLICY/ MISSED APPOINTMENT CHARGE

Payment is required at time service is rendered. Returned checks are subject to a service charge. A minimum of 48-hours advance notice is required if a patient must cancel or reschedule their appointment. A missed appointment fee will be charged for missed appointments without the minimum 48-hour notice.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Digestive Disease Associates for services rendered by the Physician(s) in person or under Physician(s) supervision. I understand that I am financially responsible for any balance not covered by my insurance company, or any service my insurance company deems not covered by my policy.

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I hereby authorize Digestive Disease Associates to release or obtain any medical or incidental information (to include HIV testing and/or treatment records, substance abuse, and/or Psychiatric care or treatment) that may be necessary for either medical care or in processing application for financial benefit. This includes all records obtained electronically (including hospitals).

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND REQUEST TO RESTRICT/EXCEPTION TO RELEASE PROTECTED HEALTH INFORMATION

We are required by law to provide you with a copy of our Notice of Privacy Practices. Should you wish to allow or restrict access of your medical records to person(s), please check one of the following:

- ☐ Restrict disclosure (release) of health information except for billing/insurance purposes as outlined in the privacy notice.
- ☐ **Release all my health information to the person(s) INDICATED BELOW**

_____

_____

_____

Signature of Patient/Legal Representative:_____ Date:_____

OFFICE USE ONLY

_____ _____

Signature of Employee receiving request Date

Request for restriction/exception has been ☐ Approved ☐ Denied

Reason for Denial:_____

_____

_____ _____

Signature of Privacy Officer Date

A Photocopy of these assignments shall be valid as the original.