Charleston Gastroenterology Specialists and Charleston Endoscopy Center

Medicare Lifetime Signature on File (for Medicare patients)
I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished me by the physician. I authorize the release of any medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services. ____________Initials

Private Insurance Authorization for Assignment of Benefits/Information Release
I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. ____________Initials

HIPAA Notice of Privacy Practices Acknowledgment
I have received, read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. ____________Initials

Agreement of Financial Responsibility for Routine, Preventive, and Non-Covered Services
Routine and Preventive services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventive, pre-existing, or non-covered, you will be responsible for the balance.
____________Initials

Authorization to Release and/or Obtain Medical Records
I hereby authorize all physicians participating in my health care, and Charleston GI Specialists' physicians, the release, use, and disclosure of my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations.
____Signature Required

Authorized Methods of Communication (check all that apply)

1. Okay to leave call back phone number only:
   ❑ Home ❑ Cell ❑ Work
2. Okay to leave detailed message on answering machine/voice mail:
   ❑ Home ❑ Cell ❑ Work
3. Okay to discuss my healthcare treatment with:
   ❑ Spouse
   ❑ Family Member____________________
   ❑ Friend______________________________
   ❑ Other______________________________

I understand that the authorization for release of information will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I acknowledge that this form and the Practice Financial Policy have been read in full and explained as necessary.

____
Date

____
Patient Name (Please Print)

____
Date of Birth

____
Signature of Patient or Personal Representative

Signoff.09.23.08