

AUTHORIZATION RELEASE

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have had the opportunity to review a copy of GI Specialists of Georgia, P.C. "Notice of Privacy Practices".

X _____ Date: _____

Patient Signature

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION:

I hereby give GI Specialists of Georgia, P.C. permission to discuss any of my Medical Information with the following people:

Name: _____ Relationship: _____

Is it permissible to leave Medical Information on an Answering Machine or Voicemail? YES NO

If yes please list phone number(s) where we can leave messages: _____

I hereby authorize GI Specialists of Georgia, P.C. to obtain and share all prescription medication history as needed for treatment.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I hereby authorize direct payment to the doctor whose name appears for surgical or medical benefits. I understand I am financially responsible for non-covered services, co-payments and any portion of deductible not paid by the insurance company.

I hereby authorize GI Specialists of Georgia, P.C. to release any information required to my health insurance provider for the purpose of processing claims for services I received from GI Specialists of Georgia, P.C.

X _____ Date: _____

Patient Signature

I hereby authorize GI Specialists of Georgia, P.C. to obtain and share prescription medication history with my pharmacy.

X _____ Date: _____

Patient Signature

PERMISSION TO TREAT:

I voluntarily allow GI Specialists of Georgia, P.C. and all medical personnel to perform diagnostic studies, tests, x-ray examination, EKG, lab work, procedures or any other treatment or examination to me during the period of medical or surgical care, they consider pertinent.

X _____ Date: _____

Patient Signature

CANCELLATION POLICIES:

Our office requires 48 business hours notice for cancellations or reschedules of office appointments or procedures. Failure to cancel or reschedule an appointment or procedure without 48 hours notice will result in a fee of \$50 for procedures and \$20.00 for office appointments. Failure to show up for a scheduled procedure will result in a \$200 fee.

PAYMENT:

Co-payments and deductibles are due prior to services being performed unless other arrangements have been made with Patient Financial Services.

We will file with your insurance as a courtesy; payment is the patient's responsibility. Any unpaid balance is due within 30 days of services rendered. Failure to pay could result in account being placed with an outside collection agency.

FEE FOR COPIES OF MEDICAL RECORDS:

In accordance with Georgia Legislative Code 31-33-3(a) there will be an administration charge for copies of all medical records.

By my signature below, I acknowledge I have read this form and I fully understand the policies and procedures.

Patient Signature: _____ **Date:** _____

Witness: _____