Advanced Care Gastroenterology Associates

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Authorization for Billing of Services

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. It is also the patient's responsibility to obtain referrals from your primary care physician when required. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and I consent to care by such providers. I understand that theses services are voluntary and that I have the right to refuse these services.

A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature: ______________________________ **Date:** ______________________

Medicare Patients Only

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished to me by the provider. I authorize the release of any medical information about me needed by my Medigap Insurer to determine those benefits payable for related services.

Patient Signature: ______________________________ **Date:** ______________________

Acknowledgement Notice & Consent of Privacy Practices

By signing this document, I acknowledge that there is a copy of the Notice of Privacy Practices for Advanced Care Gastroenterology Associates available to me. I am also giving my written consent for use and disclose of my personal health information as described in the Notice of Privacy Practices. I understand that I have the right to revoke this consent at any time by giving written notice. Should you have any questions, concerns, or complaints, you may contact the Privacy Officer: Krysten Blouin, Medical Assistant.

I authorize Advanced Care Gastroenterology, LLC (Sobia Ali, MD) to disclose my health information to the following persons:

Name	Phone Number
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________

Patient Signature: ______________________________ **Date:** ______________________