PATIENT SIGNATURE FORM

*_____ Privacy Notice

I hereby acknowledge that I have received the Notice of Privacy Practices from Advanced GI.

_____ *In lieu of the patient signature, I _____, a staff member of Advanced GI, state that this patient has been given our current Notice of Privacy Practices.*

(See Advanced GI's Notice of Privacy Practices posted on the website: **www.AdvancedGIOnline.com**.

*_____ Authorization to Discuss My Account

It is the policy of this practice to call our patients to reschedule appointments if necessary, to confirm appointments for a future date, and to inform you of test results. When we will call you, we may leave a message on your answering machine or speak with whomever answers the phone. Your initials on this section indicate that this is acceptable to you. If this is not acceptable, please let us know upon registration so that we can note this in our computer.

*_____ Consent to Treat

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

*_____ Release of Information and Assignment of Benefits

I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize Advanced GI to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, or mental illness. I hereby assign to Advanced GI payments made by my insurance carrier until such time as I revoke this in writing.

*_____ Patient Financial Responsibility

I understand that Advanced GI will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. If there is any question regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve this. I also understand that I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance and that any unpaid charges over 60 days old will become my responsibility, with payment due from me plus processing costs. In the event my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (up to 30% of the balance placed for collection). In addition, I will be responsible for all court costs, filing fees, and attorney fees should this account require litigation.

My signature in the box below indicates my knowledge of and agreement with all of the above. Further, I understand and agree that my consents/assignments remain in effect until I choose to revoke them in writing.

_____

(Signature of patient or authorized representative) (Printed name) (Date)

_____

(If signed above by representative, relationship of signer to patient) (Name of patient if different from above)

******* *Medicare Patients: Please complete other side* *******

********** ***For Medicare Patients Only*** **********

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to Advanced GI for services provided to me by the above physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

_____

(Beneficiary/Patient signature) (Date)

Medi-Gap Assignment of Benefits (Medigap = Secondary Insurance)

I request that payment of authorized Medi-Gap benefits be made on my behalf to Advanced GI for services provided to me by the above physicians. I authorize any holder of medical information about me to release to my Medi-Gap insurer any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

_____

(Beneficiary/Patient signature) (Date)