



ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT

(This is necessary for the processing of insurance claims and to assure payment.)

1. I hereby authorize and give permission for Associates In Gastroenterology to disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing Associates In Gastroenterology to release all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance, and any other insurance plan.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays, and co-insurance, and that copays are due at the time the services are rendered.
4. I understand and agree that in the event I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.
5. This office reserves the right to charge a handling fee for any unpaid balance.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Signed: _____ Date: _____

CANCELLATION POLICY

Associates In Gastroenterology requires **24hours notice** should you find it necessary to cancel your office appointment. If you fail to cancel within this time frame, you will be charged **\$50.00**.

Due to prep time required for out-patient procedures, we require a minimum of **48hours** notice for cancellation of any out patient procedure. If you fail to provide us with **48 hours notice**, you will be charged **\$150.00**.

Signature: _____ Date: _____