Allied Digestive Health

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Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: _____

- I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
  Please note: A Doctor's Prescription is NOT a valid Referral.
- I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co- pays, co-insurances, deductibles, and non-covered services.
- I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.
- I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.
- I will provide all current insurance ID cards (we require both sides of your insurance card) at the time of service as well as a current photo ID.
- I understand that I will be charged $35 for any check returned by my bank for any reason.

Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Allied Digestive Health for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. **I understand that I am ultimately financially responsible for payment of all services regardless of any insurance coverage that I may have.** A photocopy of this authorization shall be considered as effective and valid as the original.

Release of Medical Records and Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or other authorized third parties involved in my case unless I have specifically instructed otherwise.

By my signature below, I acknowledge that I understand and agree to these terms:

_____ _____

Signature of Patient or Guardian | Today's Date

_____

Printed name of Patient or Guardian