

Southeastern Indiana Gastroenterology, LLC. (SEIG)
GENERAL CONSENTS / FINANCIAL AGREEMENT

Patient Name _____ **Date of Birth** _____

Notice of Privacy Practices - Copies of SEIG's Notice of Privacy Practices are in the waiting room.

Release of Medical Records Information

I authorize the release of medical record information to those parties that have agreed to maintain the confidentiality of such information pursuant to applicable law. This authorization extends to records relating to communicable diseases, drug and alcohol abuse treatment records protected by 42C.F.R. Part 2, and mental health records. I understand this consent to release medical record information may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on the consent.

I agree for SEIG to disclose any health information with regard to my care and treatment to the following *individuals/family members*:

Name	Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree to allow SEIG physician and staff to leave appointments, simple results and instructions on my home answering machine, voice mail, cell phone or work phone unless crossed off.

Payment Guarantee / Assignment of Benefits

In consideration of services delivered by Southeastern Indiana Gastroenterology (SEIG), the undersigned understands, agrees and guarantees the following:

1. I hereby authorize, request and assign payment directly to SEIG covering this treatment and future treatments, by all insurance carriers with whom I have coverage.
2. I understand that I am responsible for any services not covered by my insurance company and that I am responsible for any applicable deductible or coinsurance amounts.
3. If my insurance plan requires any form of care management, such as prior authorization or referral, I will notify SEIG in advance; so they may assist me in getting the required approvals.
4. If any amount due SEIG becomes delinquent I will be responsible for any and all expenses including reasonable attorney fees incurred in collecting the delinquent amount.
5. If services are provided to a child the undersigned will be responsible for payment under these same terms.

Signature of Patient / Legal Representative

Date

Print Name (person responsible for payment) if different from above.

Date