BLOUNT GASTROENTEROLOGY ASSOCIATES, PC

Please read this information carefully. If you have any questions, please speak with staff before signing.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing a claim for you. Copays are due at the time of service. When insurance has processed and paid/denied your claim you will be billed for the patient responsibility which is **due upon receipt.** The undersigned individual guarantees prompt payment of all charges incurred. Fees (including, but not limited to, attorney fees) that are related to the collection of delinquent accounts will be borne by the patient. You agree that you may be discharged from this practice if your account becomes delinquent and/or is placed with an attorney or collection agency for collection.

My signature below indicates that I have received a copy of the office's Billing Procedures related to my office visit today with the provider, as well as any future office visits with Blount Gastroenterology Associates, PC or future procedures with Tennessee Endoscopy Center.

ASSIGNMENT OF BENEFITS

I hereby assign benefits to be paid, on my behalf, to the physician who renders service to me. I understand and agree to assist in obtaining payment from my insurance company if charges are not paid within a reasonable period of time. I certify that the information given with regards to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the Physician rendering service to release all or part of my medical records when required for submission of any insurance claims for payment of services rendered by the Physician. The Physician, its agents, servants and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

MESSAGES

I authorize the Physician or physician's staff to leave on my answering machine or at the telephone numbers indicated on registration forms and with the people listed below in regards to lab results, prescriptions, verification of appointment or test results. The Physician, its agents, servants and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

1) ____________________________ 2) _________________________________ 3) _________________________________

NOTICE OF PRIVACY ACKNOWLEGEMENT

I hereby acknowledge that I have been given a copy of the Notice Of Privacy Practices.

CERTIFICATE

The undersigned certifies that he/she had read and understands the foregoing and fully accepts terms specified above.

____ ____

Signature / Date | Signature of Guardian/Responsible Party/ Date

____ ____

Print Name | Print Name

*****For Office Use Only
If not signed, reason why acknowledgement was not obtained: ____

Staff seeking acknowledgement:____ Date:___________________

Revised 07/2008