CONSENT FOR TREATMENT
COMMUNICATIONS CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of _____ _____ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Health Specialists, LLP, and its employees and agents (together, FDHS). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDHS.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDHS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDHS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDHS. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize FDHS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

COMMUNICATIONS CONSENT

_____(initial) I authorize Florida Digestive Health Specialists (FDHS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):

_____

_____(initial) I authorize FDHS to contact PATIENT at the following email address:

_____

_____(initial) I authorize FDHS to share PATIENT medical information with

_____(Name and Relationship)

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDHS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

_____
Signature of Patient or Patient's Legal Representative

_____
Name of Patient's Legal Representative and relation to Patient

Date:_____

_____
For Office Use Only:

I personally delivered the Notice of Privacy Practices to the above-named patient (or authorized representative of the patient). A written acknowledgement of receipt by the patient or representative was not obtained for the following reason(s):

_____

_____ _____
[Signature of Office Staff Member] [Date]

Name: _____

MR#_____

FLORIDA DIGESTIVE HEALTH SPECIALISTS, LLP

FINANCIAL POLICY

Our practice strives to provide optimal care, and we want to ensure you fully understand our Financial Policy.

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. A minimum charge of $25.00 will be assessed on all returned checks.
2. Please be advised that your insurance policy is a contract between you and your insurance company.
    a. Our providers participate with many insurance companies and other health plans. Our billing department files the claims and accepts the assignment of benefits on these claims. The insurance company pays Florida Digestive Health Specialists, LLP (FDHS) directly for all claims filed by our billing service.
    b. If we do not have a contract with your insurance company, you will be required to pay for the medical services provided at the time of your visit. However, we will provide you with a summary of your visit in the form of an itemized receipt. You can submit this itemized receipt to your insurance company for reimbursement if they cover such expenses. If your insurance company approves the charges, they will pay you directly.
3. Not all insurance companies cover all services. If your insurance company determines a service to be "non-covered," you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.
4. If you provide incorrect or false information resulting in claim denial, you are responsible for unpaid claims and service charges.
5. We will bill your insurance company for services provided to you in a hospital setting. You are responsible for any balance due if your insurance company does not pay.
6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, including but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.
7. We require 24-hour notice for office visits if you cannot keep your appointment for any reason. If you do not provide the required notice, your account will be charged a $50.00 no-show fee. If you do not give 72-hour notice that you are canceling your procedure(s), you will be charged a $75.00 no-show fee.
8. If the patient or responsible party fails to pay for services rendered under standard practices, such nonpayment will result in the patient/undersigned's provider and all providers of FDHS terminating their provider relationship with the patient/undersigned in accordance with applicable law. Any outstanding balances for services provided will be sent to a collection agency.

I have read and understand the FDHS Financial Policy and agree to be bound by its terms. I also understand and agree that FDHS may amend such terms occasionally.

_____ _____

Signature of Patient (or Responsible Party) Date

_____

Patient Name (Print)

_____ _____

Print Name of Responsible Party (Print) (if different from Patient) Witness