OFFICE POLICY

MEDICARE SIGNATURE

I request that payment of approved Medicare benefits be made on my behalf to Gastrointestinal Specialists of Miami, Inc. for any services provided to me by the physician. I approve any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: ____ Date:___/___/______

COMMERCIAL INSURANCE

Routine/Screening Liability Waiver

Subscriber Agreement:

I comprehend that in some cases my insurance company due to plan and/ or policy may deny certain services. In the case of denial by my insurance company, I comprehend and agree that I am **responsible** for the payment of these services.

Gastrointestinal Specialists of Miami, Inc. believes in your case that your insurance carrier may deny payment of the services because of policy limitations and/ or refusals. If your insurance carrier denies payment for any of your bills, you will be personally and fully responsible for the payment.

Patient Signature: ____ Date:___/___/______

PATIENT FINANCIAL AGREEMENT

Gastrointestinal Specialists of Miami, Inc. would like to thank you for choosing us as your healthcare provider. We are committed to your treatment being successful.

Regarding insurance, we will submit a claim to your insurance carrier. HIPAA regulations request our office to inform you of the need to disclose patient information to your health insurance company for payment. This notice is effective as long as you are an established patient.

Our financial policy was designed to give you a number of payment options to choose from in order to accommodate each financial situation. We request that all co-payments be paid at the time of service. You may use cash, credit card, or check as payment.

SINCE EACH INSURANCE POLICY IS DIFFERENT, WE ADVISE YOU TO CONTACT YOUR INSURANCE COMPANY FOR YOUR INDIVIDUAL BENEFITS AND POLICY QUALIFICATIONS.

I understand and agree to the above statement.

Patient Signature: ____Date:___/___/____