

**Metropolitan Gastroenterology Associates, Inc.
MGA GI Diagnostic & Therapeutic Center, Inc.**

**CONSENT FOR RELEASE OF INFORMATION
FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

I, _____, hereby authorize Metropolitan Gastroenterology Associates, Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the physician can refuse to treat me.

I have been informed that Metropolitan Gastroenterology Associates, Inc. has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Metropolitan Gastroenterology Associates, Inc., in writing, but if I revoke my consent, such revocation will not affect any actions that Metropolitan Gastroenterology Associates, Inc. took before receiving my revocation.

I understand that Metropolitan Gastroenterology Associates, Inc. has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Metropolitan Gastroenterology Associates, Inc. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Metropolitan Gastroenterology Associates, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, it must adhere to such restrictions.

_____ Initial here to give us permission to speak with someone in your household regarding your care or account status. List person(s): _____

Signature of patient or patient's representative
(Form *MUST* be completed before signing.)

Date

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Please understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your health plan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

All payments are due at the time of service. All patient-due amounts must be paid within 30 days. If this creates a financial hardship for you, please contact our business office. In no case can we extend payment past four (4) months. All past-due accounts are placed with an outside agency for collection.

Checks returned for non-sufficient funds must be paid within five (5) business days from the time we notify you. Uncollected NSF checks are placed with the Sheriff's office for collection.

Signature of patient or patient's representative

Date

To Be Completed if Patient is Unable to Sign:

Printed name of patient's representative

Relationship to the patient