Gastroenterologists, Ltd.
Bucks County GI Endoscopic Surgical Center, LLC
1339 Woodbourne Rd.
Levittown, PA 19057-1504

***Please initial*:**

INSURANCE AUTHORIZATION AND ASSIGNMENT

_____ I request that payment of authorized Medicare/other insurance company benefits be made to Gastroenterologists, Ltd./Bucks County GI Endoscopic Surgical Center, LLC for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare/other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

***Please initial*:**

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

_____ I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Gastroenterologists, Ltd. /Bucks County GI Endoscopic Surgical Center's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

***Please initial*:**

ACKNOWLEDGEMENT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

_____ I hereby acknowledge that I have received a copy of the Notice of Patient Rights and Responsibilities.

_____
Patient Name (Print)

_____ _____/_____/_____
Patient Signature Date