Digestive Disease Associates P.A.

Specializing in diagnosing and treating gastrointestinal, biliary and liver disorders.

FINANCIAL POLICY, RECORD AND MEDICATION HISTORY RELEASE AND HIPPAA ACKNOWLEDGEMENT

FINANCIAL POLICY FOR DIGESTIVE DISEASE ASSOCIATES (DDA)

- **For patients with insurance:** Co-payments, coinsurance and/or deductibles are the responsibility of the patient or responsible party and due at the time of service. It is the patient's responsibility to obtain a written referral and authorization if their insurance carrier requires the same. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.
- **For patients without insurance:** I understand that payment for services rendered by DDA is due and payable in full at the time services are rendered, unless prior arrangements have been made with an employee of DDA.
- **In the event** the Patient submits payment by check and that check is returned for any reason by the Bank, DDA will add $30.00 to the balance owed by the Patient or Responsible Party.
- **No statement by an employee** or agent of DDA will contradict, void, or nullify this Agreement, nor shall the patient rely on any statements or opinions made by DDA that Patient's insurance carrier will pay the bill.
- **Payments:** Unless other arrangements are approved by DDA in writing, the balance on your statement is due and payable when the statement is issued, and past due if payment is not received within 60 days after adjudication by your insurance carrier.
- **Past due accounts:** If your account becomes past due, we will take the steps necessary to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collection costs that are incurred, including attorney fees and court costs, if applicable. Any balance unpaid after 60 days from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent
- **Waiver of confidentiality:** You understand if your account is submitted to an attorney and/or collection agency, if DDA has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and that your account is delinquent with DDA will become a matter of public record.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I give my consent for treatment and authorize the release of clinical information to other medical professionals who have need of such use for the provision of my care. **I hereby authorize DDA** to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf. **Authorization is hereby given to** DDA to submit all claims directly to my insurance company on my behalf and authorize my insurance carrier to forward payment directly to DDA.

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide information below on how we should contact you)

I hereby authorize DDA to communicate information regarding my evaluation, diagnosis, treatment and billing to/with:

- My spouse/family member/other Name: _____ _____ Initials
- My spouse/family member/other Name: _____ _____ Initials
- If, when calling, we reach an answering machine or voicemail message, may we leave a message? ○ **Y** ○ **N** _____ Initials

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I authorize DDA to obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of my treatment.

AUTHORIZATION AND ACKNOWLEDGEMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Digestive Disease Associates as described above, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested in the section titled Confidential Communication of Personal Health Information, that I give authorization to DDA to obtain my Medication History as indicated above and that I have received a copy of the Digestive Disease Associates Notice of Privacy Practices.

_____ _____

Signature of Patient or Parent/Guardian, if minor Date

_____ _____

If Responsible Party, Please Print Name Relationship to Patient

_____ _____

Witness ***Account # (For Office Use)***