Northeast Gastroenterology Associates

Signature on File, Assignment of Benefits, Financial Agreement

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Beneficiary Name (Print) Medicare Number

1) **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Bustleton Gastroenterology Assoc., for services furnished me by Bustleton Gastroenterology Assoc.. I authorize any holder of medical information about me to release to Bustleton Gastroenterology Assoc. for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any conformation needed to determine these benefitsor the benefits payable for related services. I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Bustleton Gastroenterology Assoc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2) **Medigap:** I understand that if a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Bustleton Gastroenterology Assoc., if possible or otherwise to me.
3) **Release of Information:** Bustleton Gastroenterology Assoc. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Bustleton Gastroenterology Assoc. for reimbursement for services rendered, and (2) any health care provider for continues patient care. Bustleton Gastroenterology may also disclose on an anonymous basis any information concerning my case, which research, for the collection of statistical data or pursuit to State or Federal law, statue or regulation. A copy of this authorization may be used in place of the original.
4) **Other Insurance:** I understand that Bustleton Gastroenterology Assoc. maintains a list of health care services plans with which it contracts. A list of such plans is available from the Business office and that Bustleton Gastroenterology Assoc. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charged of all services rendered by Bustleton Gastroenterology Assoc. if I belong to a plan that does not appear on the above mentioned list.
5) **Non-Covered Insurance:** I understand that Bustleton Gastroenterology Assoc.'s contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of noncovered services include, but are not limited to, services not specified as being covered in the patients' contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patients; and treatment or tests not authorize by the health care service plan. The undersigned agrees to cooperate with Bustleton Gastroenterology Assoc. to obtain necessary health care service plan authorization.
6) **Financial Agreement:** I agree that in return for the services provided to the patient by Bustleton Gastroenterology Assoc., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Bustleton Gastroenterology Assoc. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits, of type under and policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Bustleton Gastroenterology Assoc.. If co-payments and/or deductibles are designated by my insurance company or health plan; I agree to pay them Bustleton Gastroenterology Assoc. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

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Beneficiary Signature or Authorized Party Date