Denver Digestive Health Specialists
shedding light on gastrointestinal problems

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LIFETIME AUTHORIZATION

Office Policies Regarding Health Insurance and Payments

I understand it is the policy of this office to collect insurance co-payments prior to being seen by the doctor. Unless I have made prior specific arrangements with the office's billing staff, I understand I am responsible for payment of all known charges not covered and/or paid by my insurance plan, and that these charges are payable at time of service. I am responsible for payment of charges assessed for return of any payment for any reason, including but not limited to Non-Sufficient Fund charges. I further understand that if your bank for any reason returns payment, checks will no longer be accepted. In the event any balance is not paid as agreed, I agree to pay all charges brought about by the collection company, including but not limited to interest and/or attorney fees if required.

If I am late for my appointment, and as a result, the doctor is unable to see me, or if I do not cancel my appointment with at least twenty-four (24) working hours advance notice, I understand that I may be charged a fee.

I understand that I bear ultimate financial responsibility for my health care. Any benefits paid by my health insurance company are a result of a contract between my health insurance company and myself. It is my responsibility to know and understand my own insurance benefits. It is also my responsibility to provide necessary referrals as required by my insurance company, and if not provided I may not be seen or may be required to pay for my visit.

I understand this office will act as a third party in good faith in insurance billing matters. Furthermore, I understand this service is provided as a courtesy, and I do not expect this office to become involved in prolonged negotiations with my insurance provider, as the ultimate responsibility for payment of charges is mine. I will provide any and all information, including but not limited to, my insurance card(s), which are required to bill my health insurance company. By my signature, I hereby authorize payment of benefits to the treating physician for all services rendered today and in the future.

I understand I may be discharged from the practice at any time and should this occur notification would be mailed to me at the last known address on record with the office.

Authorization for Release of Medical Records

I authorize this office to release my medical information, including test results, radiology and procedure reports, diagnoses and any other necessary records pertaining to recommend treatments or procedures, or prescription medications.

I also authorize the release of information to another physician or facility where continuing care will be rendered. This information is confidential and it is expressly understood that any person, office or organization that receives this information is not authorized to release it in any form to anyone else without my further written authorization directly to that entity. A copy of this authorization shall be valid as the original.

This authorization does not permit release of any information (medical or billing) to any other party, including but not limited to my spouse, my parent(s) or my child(ren), with the exception of my insurance carrier or another treating health care provider. This release may be revoked only by a written, signed request.

I , THE UNDERSIGNED, HAVE READ THIS LIFETIME AUTHORIZATION, UNDERSTAND ITS CONTENTS AND AGREE WITH ITS CONDITIONS.

SIGNED: _____ **DATE**: _____
(Patient)

Printed Legal Name: _____

Social Security Number: _____ Date of Birth _____

SIGNED: _____ **DATE**: _____
(Parent, Legal Guardian, Durable Power of Attorney or other legally responsible party)