Patient Name_____ DOB_____

AGREEMENTS AND AUTHORIZATION CONSENT TO HEALTHCARE SERVICEES

- I, (the Patient signing below, or person signing below who is responsible for consenting on patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants or designees, and carried out by physicians or personnel at Advanced GI, LLC.
- I understand that I have the right to refuse this care, treatment or other services, as long as refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments, medications, tests, or examinations provided by Advanced GI, LLC.

PAYMENT GUARANTEE

- In consideration of the services provided by Advanced GI, LLC to Patient, I agree to 1.)Guarantee payment of all charges that are related to the services provided to the Patient; 2.)For all time assign and transfer to Advanced GI, LLC all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and 3.) Authorize payment of these benefits directly to Advanced GI, LLC.
- I agree that Advanced GI, LLC is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be. This is solely the responsibility of the Patient and/or Patient's representative.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- **I agree to pay the entire copayment amount at time of service, prior to being seen by any physician or medical paraprofessional of Advanced GI, LLC, and I understand that my VISIT WILL BE RESCHEDULED IF COPAYMENT IS NOT PAID AT TIME OF SERVICE.**
- I understand and agree that my patient balance, after insurance payment, and inclusive of deductible or copayments is payable upon receipt of statement. Larger balances must be paid off within 5 monthly payments maximum. If my balance is not paid in full in 5 months, I understand my account will be sent to a collection agency.
- Any and all outstanding balances must be paid in full before future procedures will be scheduled.
- I understand that I will be charged $100.00 cancellation/no show fee if a minimum of 72 hours is not given prior to having a procedure at any location. The fee is non-reimbursable by insurance and must be paid in full before future appointments/procedures will be mad. This applies to all patients with any or no insurance
- Patient is responsible for costs of sending pathology slides to any organization for a second opinion

FOR MEDICARE PATIENTS

- I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.
- I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.
- I authorize payment of benefits to Advanced GI, LLC on the Patient's behalf.

REVISIONS OR CHANGES TO THIS FORM BY YOU OR YOUR REPRESENTATIVE WILL BE ACCEPTED BY ADVANCED GI, LLC

This agreement and authorization form covers services I receive from Advanced GI, LLC with no expiration date unless revoked by me in writing sooner, or restricted to a shorter time period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Signature of Patient/Representative Relationship Date

Signature of Witness Print name