Assignment & Release

I, the undersigned, have insurance coverage with ____and assign directly to
Name of Insurance Company

The Gastroenterology Center of Virginia, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I authorize the use of this signature on all my insurance submissions. I also understand The Gastroenterology Center of Virginia, PLLC is not an Authorized provider with **TRICARE.** I understand this means I will be solely responsible for the bill and that neither the facility nor I will submit a claim for the services to **TRICARE**. Thus, I am exempting the facility from the Balance Billing rules for the specific treatment episode of care.

____ ______________________________
Signature of Patient/Insured/Guardian **Date**

Bank Fees, Service Charges, Collection Agency and/or Attorney Fees

A $25.00 fee will be assessed for each returned check or any account balance that is past due. I understand that I am financially responsible for all related bank or service charges. I also understand that if my past due balance is sent to a collection agency for non-payment, I will be responsible for any collection and/or attorney fees.

____ ______________________________
Signature of Patient/Guardian **Date**

Release of Medical Records

I, the undersigned, authorize the release of information, including financial information, confidential health information and medical records regarding services rendered during this episode of care or any related services to my insurance carrier(s), managed care plan or other payor, and/or independent contractor physicians such as anesthesiologist and/or pathologist. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, substance abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released and thereby release The Gastroenterology Center of Virginia, PLLC and their staff from all legal responsibility that may arise from the act hereby authorized.

____ ______________________________
Signature of Patient/Guardian **Date**

I, the undersigned authorize The Gastroenterology Center of Virginia, PLLC to speak with the listed persons regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by The Gastroenterology Center of Virginia, PLLC to the listed persons and thereby release The Gastroenterology Center of Virginia, PLLC and their staff from all legal responsibility that may arise from the act hereby authorized.

Authorized Person	Relationship to Patient	Phone Number
____________________	____________________	____________________
____________________	____________________	____________________

____ ______________________________
Signature of Patient/Guardian **Date**