Patient Name: **Date of Birth:**

Authorization to Release Information: I authorize ADDC to release any medical or other information about the patient that may be necessary for the treatment, payment or healthcare operations of the facility including the proper filing of all insurance claims, review of services or receipt of benefits.
Assignment of Benefits: The undersigned assigns to and authorizes direct payment of benefits to the ADDC and agrees to assist I processing all claims for benefits.

MEDICAL INFORMATION RELEASE: At times you may want another person(s) to obtain your test results or request medication refills when you are unable or prefer to do this. All medical information contained in your medical record is strictly confidential and available only to you. If you would like someone else to have access to this information, we must have a signed consent from you. If someone other than the person(s) listed below requests information, it will not be given. This authorization may be revoked at any time.

I, the undersigned, authorize the following person(s) to obtain medical information as explained above in my behalf.

Name_____ Relationship_____

Name_____ Relationship_____

_____ I do not authorize any other person(s) to obtain my information on my behalf.

_____ _____
Patient Signature Date

HIPAA PRIVACY NOTICE: In accordance with the HIPAA Privacy Regulations this notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I, the undersigned, acknowledge that I have received ADDC's **Notice of Privacy Practice** effective September 23, 2013. (may sign at office when you get your brochure)

_____ _____
Patient Signature Date

FINANCIAL POLICY: Thank you for allowing us the opportunity to participate in your medical care. We would like to assist you in understanding the financial policies of this office. If you have any questions regarding this policy or your insurance coverage, please ask for assistance.

- We will file certain primary and secondary insurances according to our contracts with your company and as you as a courtesy to you. The patient/responsible party is ultimately responsible for payment of all services
- **Co-payments, deductibles, and non-covered services are due at the time of service**. We accept cash, check, Visa and MasterCard. There is a fee for all returned checks of $30 (post-dated checks not accepted).
- If scheduled for a procedure, **co-payment, deductible or co-insurance is due by the date of your procedure**. Advance payment may be made.
- If services recommended are considered "non-covered", we will notify you in advance and ask you to sign and "Advance Beneficiary Notice"
- In the event your insurance does not pay within 60 days, we account may be forwarded to you for payment.
- **Accounts over 60 days past due may be sent to a collection agency or attorney and your future status with the practice will be considered at that time. You are responsible for payment of collection fees such as collection agency percentage or attorney fees**
- Refunds are processed monthly and mailed by the 10th day of the month. Lost refund checks will require "stop-payment" fee which will be deducted from replacement refund check.
- Fee for Office Visits not cancelled with a **24-hour** notice: **$25**, Fee for Procedures not cancelled with **48-hour** notice: **$50**

Financial Responsibility: I have read, understand, and agree to follow the financial policy Alabama Digestive Disorders Center, PC. I agree to be totally responsible for all charges for services rendered including any non-covered charges. I also understand that if the unpaid account is referred to a collection agency or attorney for collection, I will pay all costs of collection.

_____ _____
Patient/Responsible Party Signature Date

Dr. Smita S. Shah has ownership interest in Crestwood Medical Center and Madison Surgery Center.