



Notice of Consent / Financial Policy

Patient Name _____ Date of Birth _____

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices of Indianapolis Gastroenterology & Hepatology dated 11/03/2016.

Financial Policy

I acknowledge that I have received the Financial Policy of Indianapolis Gastroenterology & Hepatology dated 05/02/2017.

Credit Card on File Policy

I acknowledge that I have received the Credit Card on File Policy of Indianapolis Gastroenterology & Hepatology dated 05/02/2017.

Signature on File – Assignment of Benefits

I authorize payment of insurance benefits to be made directly to Indianapolis Gastroenterology & Hepatology for services rendered. I authorize release of medical information to the insurance carrier and its agents for determination of benefits. I authorize release of any information to Centers for Medicare and Medicare Services (CMS) necessary for determination of benefits.

Electronic Notification Consent

I acknowledge that by providing my cell number(s) and email address, that I am giving my express written consent that “client name” and its affiliates, have authorization to contact me by text and by email address that I have provided for any non-urgent communications that would be associated with my account. Any communications related to patient health information will be encrypted.

Telephone Consent

Telephone Consumer Protection Act (TCPA).

I acknowledge under the TCPA that by providing my land line and/or cell phone number, that I am giving my prior express written consent that “client name” and its affiliates and business partners, have the authorization to call via auto-dialer, pre-recorded voice messages, SMS messages and live calls for communication that would be associated with my account in this practice.

Permission to Leave Messages

I authorize IG & H to leave health information on the following voicemail (_____) - _____ (_____) - _____

Permission to Disclose Medical and Billing Information

I authorize IG&H to disclose medical and billing information to the family and/or individuals below who are directly related to my care or responsible for payment of services related to my care. IG&H may disclose this information as deemed necessary to notify the following individuals for my general condition, location or death. I understand that this permission may be revoked by me in writing at any time.

Table with 4 columns: Name, Phone#, Relationship. Includes three empty rows for data entry.

Signature of Patient / Legal Representative _____ Printed Name (if signed by Legal Representative) _____ Date _____ 05/02/2017