Gastroenterology Specialists of Delaware, LLC

George Benes, M.D. Michael J. Brooks, MD

As a patient of GI Specialists of DE, I understand that there may be occasions where the office staff may need to contact me regarding appointments, the scheduling of tests, test results, medications, etc. In such event, I am unavailable; I authorize GI Specialists of DE to discuss my medical record (including test results and plan of care) with the following individuals. This authorization also includes the leaving of voicemail messages on my home, work, and/or cell phone. I give GI Specialists of DE permission to discuss my personal health information as stated above with the following individuals:

Name _____Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

☐ Check this box if you do not have anyone that you would like us to release your medical information too.

I understand that I may revoke this authorization at any time by notifying the office in writing of my desire to do so.

Patient Name: _____ DOB: _____

X _____ Date: _____

Signature of Patient or Responsible party

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Notice of Privacy Practices

By signing this form, you acknowledge that you have been offered a copy for review of GI Specialists of DE Notice of Privacy Practices. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice or if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (302) 832-1545.

Notice Financial Policy

- I understand that it is my responsibility to provide our office with current, accurate billing information at the time of check in and to notify us of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care copayment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that it is my responsibility to obtain a referral from my PCP if required or I will be responsible for payment.
- I understand that there is a $25 fee to complete disability paperwork associated with my care and a $15 fee to complete FMLA paperwork. All paperwork fees must be paid prior to completion.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the third statement will be marked as "Final Notice" and will be sent to an outside collection service if I do not fulfill my financial obligations. I understand that if my account is turned over to a collection agency a service charge will be added to the balance.
- **GI Specialists of DE reserves the right to charge a cancellation fee for missed or cancelled *office visits* without 24 hours advance notice of $30.00**
- **GI Specialists of DE reserves the right to charge a cancellation fee for missed or cancelled *procedures* without 48 hours advance notice of $75.00.**

My signature below confirms that I have read the above policies and understand my obligations as a patient.

Patient Name: _____ DOB: _____

X _____ Date: _____

Signature of Patient or Responsible party