CONDITIONS OF REGISTRATION/FINANCIAL POLICIES

This policy is to outline the expectations we have of you as a patient of GI Associates of MD and/or its physicians, employees, agents or assignees hereafter referred to as "The Practice." We are committed to providing you with the best possible medical care and are pleased to discuss this policy with you at any time. Your clear understanding of our Financial Policy is important to our ongoing professional relationship.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

_____AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child (ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to be made to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and benefit coverage.

_____RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare and Medicaid Services, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staff to release me or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

_____REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires referrals, pre-certifications or authorization to receive any medical services that such authorization be obtained prior to any appointment with any of the Practice's physicians. Choosing to see us as a specialist without proper insurance approval, I understand this may cause reduced or rejected coverage for which I will be held financially responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my claims. Any denial of claims is between the policy holder/subscriber and their insurance company. I (we) agree to inform The Practice immediately of any change in insurance coverage, benefits and/or change in personal information.

_____FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I, the undersigned further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself and/or my minor child (ren). I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, anesthesiologist, pathologist, facilities, radiologists, and laboratories, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or conformation. I agree to pay a $50.00 fee for office visit appointments that are not cancelled at least 24 hours in advance or missed all together. I also agree to pay a $75.00 fee for procedure appointments that are not cancelled at least 48 hours in advance or missed all together. I understand that visits as a self-pay patient, missed appointment/late cancellation, will be my financial responsibility and will not be billed to any insurance company. Should any balances arise due to insurance co-

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payments, co-insurance, deductibles, non-covered services/procedures, termination of coverage, not adding a dependent to an insurance plan, non-payment at time of service or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned for any reason, I will be responsible for a $35.00 returned check fee in addition to the original fees for services. If the balance is not paid within 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this could affect my (our) credit rating. If this account is placed for collection by an outside agency or attorney, I agree to pay any and all fees incurred by the Practice for these services. Any expenses incurred by such collection actions, including maximum allowed service charge, shall become an additional liability for which I (we) assume full responsibility.

_____COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

_____CERTIFICATION

I certify that the information I have reported regarding my insurance coverage is correct and that the above be honored by my insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the foregoing and as the patient and/or parent/guardian/guarantor understand and fully accept the terms therein.

I certify that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on this document.

_____

Signature of Patient/Parent/Guardian/Guarantor

_____

Print Name

_____

Date