Southeastern Indiana Gastroenterology, LLC. (SEIG)
GENERAL CONSENTS / FINANCIAL AGREEMENT

Patient Name ____ Date of Birth________________

Notice of Privacy Practices - Copies of SEIG's Notice of Privacy Practices are in the waiting room.

I agree for SEIG to disclose any health information with regard to my care and treatment to the following *individuals/family members*:

Name	Phone #	Relationship
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________

I agree to allow SEIG physician and staff to leave appointments, simple results and instructions on my home answering machine, voice mail, cell phone, email or work phone unless crossed off.

Payment Guarantee / Assignment of Benefits

In consideration of services delivered by Southeastern Indiana Gastroenterology (SEIG), the undersigned understands, agrees and guarantees the following:

1. I hereby authorize, request and assign payment directly to SEIG covering this treatment and future treatments, by all insurance carriers with whom I have coverage.
2. I understand that I am responsible for any services not covered by my insurance company and that I am responsible for any applicable deductible or coinsurance amounts.
3. If my insurance plan requires any form of care management, such as prior authorization or referral, I will notify SEIG in advance; so they may assist me in getting the required approvals.
4. If any amount due SEIG becomes delinquent I will be responsible for a $50 collection fee which will be added to my balance and all expenses including reasonable attorney fees incurred in collecting the delinquent amount.
5. If services are provided to a child the undersigned will be responsible for payment under these same terms.

____ ____ __________________
Signature of Patient / Legal Representative **Date**

____ __________________
Print Name (person responsible for payment) if different from above. Date