Henry Levine M.D. | William Mayoral M.D. | Marlon Ilagan M.D. | Samuel Giday M.D.
Jason Korenblit M.D. | Ehsan Rafiq M.D. | Ivelisse Lopez M.D. | Xinjun Zhu M.D.

1817 North Mills Ave. Orlando Fl. 32803

Center for Digestive Health

Account#_____

Patient: First Name_____ Last Name_____ DOB_____

Address: _____

Contact: Tel#_____ Cellphone#_____

Referring Dr: _____ PCP:_____

Tel# _____ Tel#_____

Reason for today's visit_____

Last Colonoscopy:_____

FINANCIAL POLICY

The doctors and staff of Center for Digestive Health and Endoscopy would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible. We ask for your help by understanding and cooperating with our financial policy.

Please read this policy and sign below confirming you understand the following:

- All payments are due at the time of service: Self pay fees, Insurance co-payments and deductibles...Any open balances such as, co-insurances and deductibles will be collected at service date. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- A return check will result in a $25 service charge and all future payments will be collected in the form of Cash or Credit Card.
- Refunds request may take up to 4 weeks from date requested, if there are no pending claims.
- There is a $25 charge for completion of paperwork (ex: disability, FMLA etc). Paperwork may take up to 7-14 days for completion.
- Any balance over 90 days old will be processed and sent to a collection agency.
- Our practice participates with several insurance companies; it is your responsibility to understand the requirements and covered benefits of your plan.
- You are responsible for any non-covered and/or denied claim; you will receive a statement of denied charges and payment is due in 30 days after date of statement.
- If your insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral faxed to our office prior to your appointment date.
- It is your responsibility to notify our office of any changes to your insurance coverage, your address and telephone number.
- You are required to cancel office appointments 24 hours prior to appointment time to avoid a $25 cancellation charge and 48 hours prior for procedures to avoid a $100 cancellation charge.

We realize that temporary financial problems may affect timely payment of accounts. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. Contact our professional staff in the Business Office; we are here to help you with any questions and issues. Call 407-896-1726.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Signature_____ Date_____

CENTER FOR DIGESTIVE HEALTH/ENDOSCOPY FINANCIAL POLICY AND PATIENT RESPONSIBILITY STATEMENT:

Payment for all services rendered by Center for Digestive Health/Endoscopy are due at the time of service unless other arrangements are made in advanced or we have a contract with your insurance plan.

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Center for Digestive Health/Endoscopy for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years of age) Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Center for Digestive Health/ Endoscopy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract, such as any deductible, co-payment, co- insurance, non-covered services, or services rendered if my insurance is terminated. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years of age Date

Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives Acknowledgement of Receipt:

I, the undersigned acknowledge receipt of the document titled Patient's Rights and Responsibilities, HIPPA Privacy Practices, and Advanced Directives.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years of age) Date

MEDICAL RECORDS RELEASE:

I hereby grant permission to Center for Digestive Health/Endoscopy to release medical information to my insurance carrier(s) in response to their request for information required to file a claim for reimbursement on MY or PATIENT'S behalf.

SIGNED: _____ (PATIENT OR GUARDIAN) DATE: _____

This is to authorize the verbal release of my medical condition, status, and/or test results, in the event that I am not home, to the following (specify all family members authorized):

_____

_____

_____

_____

Signature Date

No expiration on authorization unless specified by patient