NEW YORK GASTROENTEROLOGY ASSOCIATES

Authorization for Assignment of Benefits (Commercial, Medicare, Medicaid)

Name of Patient

Name of Insurance Company

Policy Number

I request that payment of authorized insurance benefits be made on my behalf to NYGA for the services provided to me by NYGA providers.

I authorize NYGA to release to my insurance company or its agents any information needed to determine the benefits payable for the services.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for the services.

I understand that I am responsible for providing NYGA with all my insurance coverage information and insurance card(s) at the time of service. I understand that I will be financially responsible to pay for the services provided, which are not covered by my insurance company.

I understand that if my health plan requires a referral from my participating primary care provider, it is my responsibility to obtain and provide this referral to NYGA prior to my visit. I also understand that if I do not provide NYGA with a referral, and choose to be seen today, I will be responsible to pay for the services.

I understand that I am responsible for any copays, deductibles, and co-insurance associated with the services.

I understand that I may be subject to the following fees for no-show or late cancellation:

- Appointments: $100 if not canceled at least 24 hours in advance.
- Procedures: $250 if not canceled at least 48 hours in advance.

I hereby consent to and authorize NYGA to store my credit card information and charge it for outstanding balances related to services rendered, copays, deductibles, cancellation fees, and no-show fees.

I understand and accept all the above statements.

Signature of Patient

Date of Service