BMG | GI SPECIALISTS FOUNDATION

Authorizations & Acknowledgments

Date: __________________ MRN____________________________

Patient Name: ____
First Middle Last

Acknowledgment of Notice of Privacy Practices

Initial Here ________ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here ________ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here ________ I authorize Baptist Medical Group to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here ________ I authorize payment directly to Baptist Medical Group for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by Baptist Medical Group and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

Communication Regarding My Account

Initial Here ________ I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as “collectors”) to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Destruction of X-ray Images/Graphic Data (MS Patients Only)

Initial Here ________ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

____
Signature of patient/parent/guardian/person authorized to sign for patient

Date: _________________

PLEASE NOTE: You will receive a separate bill from **BMH-GILAB2**, representing the charges for the procedure (this is called a facility charge). If your insurance requires a co-pay, you will receive a phone call from the surgery center prior to your procedure, asking you to bring your co-pay on the day of the procedure. This payment will be applied to the **BMH-GILAB2** bill. Again, this bill and co-pay is separate from **BMG-GI Specialists Foundation** billing.