

Release of Medical and Billing Information

Please read over carefully!! If you do not wish to have your medical or billing information released to anyone please skip this part.

I authorize the physicians of Lebanon Digestive Disease Associates, PLC and their staff to release any information on file regarding my medical condition, treatment or billing information to the following person(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that by signing this release the designated person(s) above will be able to speak to any member of the Lebanon Digestive Disease Associates, PLC staff concerning my records. Furthermore, I understand that the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account information.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Rights and Responsibilities

*****Please read the following carefully and initial*****

(1) I have received a copy of my right to privacy notice (HIPAA).

Initials _____

(2) I certify to the best of my knowledge that the above information is complete and accurate. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to this office for any services furnished me by the providers of Lebanon Digestive Disease Associates, PLC. I authorize the release to Medicare or any other insurance carrier and/or agents any information necessary to determine benefits payable.

Initials _____

(3) I accept full responsibility for payment of my bill including any deductibles, non-covered services, or in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary Care Physician prior to being seen in this office. If seen without a referral, I understand I will be financially responsible for any services rendered.

Initials _____