RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I, hereby authorize Pediatric Gastroenterology Specialists of Maryland to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment form my care will be released. I agree that a copy of this release may be used in place of the original. I am aware that I may request the Release of Medical Information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

NOTICE OF FINANCIAL INTEREST

Federal regulations require that we inform you that the physician below has a 100% financial interest Pediatric Gastroenterology Specialists of Maryland. An interest in this facility enables them to have a voice in the administrative and medical policy of this healthcare institution. This involvement helps us ensure the finest quality surgical care for their patients.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Pediatric Gastroenterology Specialists of Maryland, or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct Pediatric Gastroenterology Specialists of Maryland, to bill, in the event of non-payment for whatever reason in accordance with the benefit of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency and or attorney, I accept full responsibility to pay the full balance due to Pediatric Gastroenterology Specialists of Maryland as well as the collection costs not to exceed 30% of the total charged by the collection agency to Pediatric Gastroenterology Specialists of Maryland, and interest of 1.5% per month on the total amount due, not to exceed 18% per annum and reasonable court costs.

I have received information on Bill Of Rights and agree to all of the above.

__________________________________ ___________________

Patient or Legal Guardian Signature **Date**

Please circle if you have ever executed an Advanced Directive: Yes / No

__________________________________ ___________________

Patient or Legal Guardian Signature **Date**