VALLEY COLORECTAL SURGEONS

PROCTOLOGY & COLORECTAL SURGERY.

CHARLES N. HEADRICK, M.D., F.A.C.S.
DANIEL S. GINGOLD, M.D., F.A.C.S.
JEFFREY P. LAKE, M.D., F.A.C.S.

Information and Assignment of Benefits

Patient Name: _____

Legal Guardian's Name (**Please Print, if applicable):** _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature: _____

I hereby authorize Valley Colorectal Surgeons to apply for benefits on my behalf for covered services rendered by them or by their order. I request that payment from my insurance company be made directly to Valley Colorectal Surgeons. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or my insurance company in writing at any time.

Date: _____ Signature: _____

Financial Policy

The undersigned hereby agrees that in consideration of services to be rendered, that the patient or legal guardian individually, jointly and severally obligates himself, herself or themselves to pay the account of Valley Colorectal Surgeons.

I understand that financial obligation is my/our own responsibility as the patient/guardian and, should the insurance company deny payment or I/we default on payment arrangements, the delinquent account will be sent to a third party collection agency.

Date: _____ Signature: _____