BEAUMONT
Gastroenterology Services

First Name: _____ **Last Name:** _____ **DOB:** _____

YES	NO	
_____	_____	**Insurance Authorization** I hereby authorize Beaumont Gastroenterology Services to bill my insurance company and to furnish information to my insurance carriers concerning my illness and treatment.
_____	_____	**Assignment of Benefits** I hereby assign to Beaumont Gastroenterology Services all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.
_____	_____	**Treatment Authorization** I hereby authorize Beaumont Gastroenterology Services to render health care to me during my office visits.
_____	_____	**Privacy Notice** I have received a HIPAA Privacy Notice that explains how my personal health information will be used.
_____	_____	**HIPAA Release** I authorize Beaumont Gastroenterology Services to release confidential medical information to the following parties: 1) _____. 2)_____.

Patient Signature _____ **Date** _____.