Gastrointestinal Specialists, PC

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OUR FEE POLICY

I understand and agree that any charges incurred are my responsibility and not that of any insurance carrier. I further agree that if my account must be placed in the hands of an attorney for collection, or if collection is made through bankruptcy or probate proceedings, I do agree to pay a reasonable attorney's fee and/or litigation.

I hereby authorize Isaac M. Jalfon, M.D., Paul S. Bierman, M.D., Kenneth I. Fields, M.D., Gerald J. Lieberman, M.D. and Edward S. Friedman, M.D. to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctor all money to which I am entitled for medical and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physician and surgeon. It's understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Responsible Party's Signature Patient's Signature Date

Authorization I,: _____ Father: _____ Mother: _____ Legal Guardian: _____

Hereby authorize Isaac M. Jalfon, M.D., Paul S. Bierman, M.D., Kenneth I. Fields, M.D., Gerald J. Lieberman, M.D. and Edward S. Friedman, M.D. to provide such medical services including surgery, if necessary, either regular or emergency as may be determined to be in the best interest of those members of my immediate family, as listed above, who are minor. This authorization shall continue and be in full force and effective until revoked in writing by me. A photocopy of this authorization shall be considered as effective and valid as the original.

_____

Patient or Guardian