Assignment of Benefits & Guarantee of Payment

Assignment of Benefits

I hereby irrevocably assign and transfer to Granite State Gastroenterology any monies or benefits to which I may be entitled, including such benefits and monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care received at Granite State Gastroenterology. I authorize and direct Granite State Gastroenterology and its physicians and other providers, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also appoint Granite State Gastroenterology as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Granite State Gastroenterology as my assignee. I further agree to provide information as necessary and to cooperate with Granite State Gastroenterology to process and obtain payments.

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Granite State Gastroenterology.

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for medical services rendered in accordance with the rates and terms of this practice or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

______________________________________ _____________

Patient Name DOB

______________________________________ _____________ ____________________________________

Signature of Patient or Representative Date Relationship of Representative to Patient