# BILLING CATEGORY ASSIGNMENT OF BENEFITS FORM

During the course of your evaluation and treatment, physicians and professionals outside of Capital Digestive Care may be involved in your care. Following a procedure, such as endoscopy or colonoscopy, it is common to be billed for physician services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. **Each entity will bill separately for services provided.** You are free to utilize any health care facility or provider of your choice, subject to the restrictions of your physician's affiliation or restrictions which may exist under your health insurance coverage.

Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

**Capital Digestive Care affiliated organizations:**

<table>
<tr><th><u>Physician Billing</u></th><th><u>Facility Billing</u><br>(one of the following)</th><th><u>Anesthesia Billing</u><br>(one of the following)</th><th><u>Pathology Billing</u></th></tr>
<tr><td rowspan="4">CAPITAL DIGESTIVE CARE, LLC</td><td>AMBULATORY ENDOSCOPY CENTER OF MARYLAND</td><td>CORRIDOR ANESTHESIA, LLC</td><td rowspan="4">CAPITAL DIGESTIVE CARE PATHOLOGY LABORATORY, LLC</td></tr>
<tr><td>BETHESDA ENDOSCOPY CENTER<br>CHEVY CHASE ENDOSCOPY CENTER<br>ENDOSCOPY CENTER OF WASHINGTON, D.C.<br>ENDOSCOPIC SURGICAL CENTRE OF MARYLAND<br>ENDOSCOPIC SURGICAL CENTRE OF MARYLAND – NORTH</td><td>CAPITAL ANESTHESIA PARTNERS, LLC (CAP)</td></tr>
<tr><td>GASTROINTESTINAL ENDOSCOPY ASSOCIATES, LLC (GIEA)</td><td>MONTGOMERY ANESTHESIA CARE, LLC (MAC)</td></tr>
<tr><td>URBANA GI ENDOSCOPY CENTER</td><td>MARKED ANESTHESIA, LLC<br>MARYLAND ANESTHESIA PARTNERS (MAP)<br>MARCOS FALTAMO, CRNA, PC</td></tr>
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1. I understand that the companies above will disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing the release of all PHI necessary for payment and treatment of my specific health problem.

2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan.

3. I understand I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays and co-insurance, and that copays are due at the time of services.

| ______________________________ | ______________________________ |
|---|---|
| Patient / Representative Signature | Date |
| ______________________________ | ______________________________ |
| Patient Printed Name | Date of Birth |