CAPITAL DIGESTIVE CARE℠
First in Digestive Health

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:

Physician Billing	**Facility Billing** *(one of the following)*	**Anesthesia Billing** *(one of the following)*	**Laboratory Billing** Pathology & Clinical Laboratory
CAPITAL DIGESTIVE CARE, LLC	AMBULATORY ENDOSCOPY CENTER OF MARYLAND BETHESDA ENDOSCOPY CENTER CHEVY CHASE ENDOSCOPY CENTER ENDOSCOPY CENTER OF WASHINGTON, D.C. ENDOSCOPIC SURGICAL CENTRE OF MARYLAND ENDOSCOPIC SURGICAL CENTRE OF MARYLAND – NORTH FALLSGROVE ENDOSCOPY CENTER GASTROINTESTINAL ENDOSCOPY ASSOCIATES, LLC (GIEA) SOUTHERN MARYLAND ENDOSCOPY CENTER URBANA GI ENDOSCOPY CENTER	CAPITAL ANESTHESIA PARTNERS, LLC CORRIDOR ANESTHESIA, LLC MARYLAND ANESTHESIA PARTNERS (MAP) MONTGOMERY ANESTHESIA CARE, LLC POTOMAC ANESTHESIA CONSULTANTS	CAPITAL DIGESTIVE CARE, LLC

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.
4. I understand my provider may order laboratory diagnostic tests to be performed by Capital Digestive Care's Laboratory. I understand that that my insurance carrier may or may not provide coverage for laboratory studies and that these rules are carrier specific. By proceeding with the diagnostic testing ordered by my provider, I acknowledge I am financially responsible for all charges not paid by my insurance company, including any deductibles, copays, co-insurance, and any charges or services deemed not covered by my insurance.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient Name (Printed) | Date of Birth