Arlington Gastroenterology Services
Hamid Kamran, MD, PA

CONTACT AUTHORIZATION *Please PRINT AND complete ALL sections below!*

May we speak to anyone else regarding your medical condition? ❒ Yes ❒ No

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Health Insurance Portability & Accountability Act (HIPAA)

I have been provided the opportunity to review the Notice of Privacy Practices. I, the undersigned, authorize Arlington Gastroenterology Services, to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facisimile to healthcare providers, hospitals, laboratories and other medical caregivers for the coordination of care for the patient listed below. I may revoke this authorization by five (5) days written notice to Arlington Gastroenterology Services.

Assignment of Benefits-Financial Agreement

I hereby authorize payment of insurance benefits to be made directly to Arlington Gastroenterology Services any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance carrier. I also authorize Arlington Gastroenterology Services to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be valid as the original.

NOTICE

Time slots for office visits and procedures are allocated per patient agreement. As a courtesy, 48 Hour Notice of Cancellation must be given to our office in order to properly allocate those available time slots. In the even that timely notification is not given patient will be responsible for appropriate charges.

Indicate where you can be reached during business hours: ☐Home ☐Work ☐Cell

May we leave you a message? ❒ Yes ❒ No

Patient Name:_____

Authorized Signature:_____Date:_____

For your security, do NOT send this form to the doctor's office via email. RESET PRINT