CONNECTICUT GASTROENTEROLOGY ASSOCIATES, P.C.

WAIVER
DISCLOSURE/AGREEMENT

PATIENT NAME: _____

REASON FOR TODAY'S VISIT:

Routine Preventive Exam…I have no medical complaint or significant problem/ Abnormality that I am aware of

Yes, my insurance plan covers Preventive Medical Services

No, my insurance plan does not cover Preventive Medical Services

I do not know if my insurance plan covers Preventive Medical Services

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I do have a problem/ complaint that I wish to have evaluated/ treated by the doctor

My chief complaint is: _____

I agree to pay for any and all medical services I receive from the doctors / providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, plan does not pay for preventive medicine visits or my failure to secure a referral from my primary care physician) I will pay for same upon written/ verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit (s) with a diagnosis that was encountered and documented in my medical record. Thus, this office cannot comply with any request to improperly alter the medical record or claim for the purpose of securing payment from any insurance carrier which may be considered a fraudulent act (s).

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

Signature: _____
Patient (or responsible party if minor)

Print Name: _____

Witness: _____

Date: _____