DIGESTIVE
CARE CONSULTANTS

IRREVOCABLE ASSIGNMENT and TRANSFER OF BENEFITS

Name of Patient: _____

Insurance Co. Name _____Ins. ID#: _____

I hereby instruct that the payment of authorized ***Medicare, Medi-cal*** and/or surgical benefits (including major medical benefits to which I am entitled) to be made directly to my physician or provider of service for any services furnished me. I authorize payment of medical benefits to ***Digestive Care Consultants*** for services rendered.

I hereby instruct and direct all private and group accident and health insurance companies to make payment of authorized medical and/or surgical benefits (including major medical benefits to which I am entitled) to be made directly to my physician or provider of service for any services furnished to me. I authorize payment of medical benefits to ***Digestive Care Consultants*** for services rendered.

I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related service(s). I also authorize the release of any medical or other information necessary to process medical payments to ***Digestive Care Consultants***.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by said insurance, including co-payments and deductible amounts.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient