E. David Brown, M.D.
Frank P. Troiano, M.D.
David C. Pound, M.D.
James A. Jacob, M.D.
J. Scott Buckley, M.D.
G. Todd Lemmel, M.D.
Brian G. Sperl, M.D.
Michael S. Morelli, M.D.
Paul K. Haynes, M.D.
Ernest J. Orinion, M.D.

Indianapolis Gastroenterology and Hepatology

"Earning Trust Through Quality and Compassionate Care"℠

Shan L. Cheng, M.D.
Andrew W. Crane, M.D.
Lucas M. Drake, M.D.
Roshani J. Desai, M.D.
Jason R. Roberts, M.D.
C. Douglas Rice, M.D.
Anne Geary, MSPAS, PA-C
Lynette Moon, MSPAS, PA-C
Emily Porter, MSPAS, PA-C
Ariana Reynolds, PSPAS, PA-C

Notice of Consent / Financial Policy

Patient Name _____ Date of Birth _____

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices of Indianapolis Gastroenterology & Hepatology dated 11/03/2016.

Financial Policy

I acknowledge that I have received the Financial Policy of Indianapolis Gastroenterology & Hepatology dated 05/02/2017.

Credit Card on File Policy

I acknowledge that I have received the Credit Card on File Policy of Indianapolis Gastroenterology & Hepatology dated 05/02/2017.

Signature on File – Assignment of Benefits

I authorize payment of insurance benefits to be made directly to Indianapolis Gastroenterology & Hepatology for services rendered. I authorize release of medical information to the insurance carrier and its agents for determination of benefits. I authorize release of any information to Centers for Medicare and Medicare Services (CMS) necessary for determination of benefits.

Electronic Notification Consent

I acknowledge that by providing my cell number(s) and email address, that I am giving my express written consent that "client name" and its affiliates, have authorization to contact me by text and by email address that I have provided for any non-urgent communications that would be associated with my account. Any communications related to patient health information will be encrypted.

Telephone Consent

Telephone Consumer Protection Act (TCPA).

I acknowledge under the TCPA that by providing my land line and/or cell phone number, that I am giving my prior express written consent that "client name" and its affiliates and business partners, have the authorization to call via auto-dialer, pre-recorded voice messages, SMS messages and live calls for communication that world be associated with my account in this practice.

Permission to Leave Messages

I authorize IG & H to leave health information on the following voicemail (_____)-_____

(_____)-_____

Permission to Disclose Medical and Billing Information

I authorize IG&H to disclose medical and billing information to the family and/or individuals below who are directly related to my care or responsible for payment of services related to my care. IG&H may disclose this information as deemed necessary to notify the following individuals for my general condition, location or death. I understand that this permission may be revoked by me in writing at any time.

Name	Phone#	Relationship

Signature of Patient / Legal Representative | Printed Name (if signed by Legal Representative) | Date 05/02/2017