NEW YORK GASTROENTEROLOGY ASSOCIATES

Authorization for Assignment of Benefits

_____
Name of Patient

_____
Name of Insurance Company

_____
Policy Number

I request that payment of authorized insurance benefits be made on my behalf to NYGA physicians for any services provided to me by these physicians. I authorize NYGA physicians to release to my insurance company or its agents any information needed to determine these benefits payable for related services.

I also understand that I will be financially responsible for payment of those medical services provided by NYGA physicians but which is not covered by my insurance carrier.

_____
Signature of Patient

_____
Date of Service