MULTIPLE AUTHORIZATION FORM – DIGESTIVE HEALTH CENTER

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. Please note there are separate service components for which you will be billed separately: A. Professional Fee – B. Procedure Room Fee – C. Anesthesia Fee – D. Laboratory / Pathology Fee

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Digestive Health Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at The Digestive Health Center may have an ownership interest in the Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at the Digestive Health Center.

*** SIGNING BELOW CONFIRMS RECEIPT OF PATIENT BILL OF RIGHTS/DISCLOSURE PAMPHLET**

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding the Digestive Health Center policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents has been offered to me upon request.

Do you have an Advanced Directive for healthcare? Yes or No (circle)

Did the patient bring a copy to The GI Endoscopy Center? Yes or No (circle)

- If provided, copy placed in patient's medical record.

<u>By signing below, I have read and agree to the Statement of Limitation pertaining to my ADVANCED DIRECTIVE.</u>

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

___________________________________	___________________________________
Signature of Patient or Responsible Party	**Print Name**
___________________________________	___________________________________
Relationship to Patient	**Date Signed**