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ADMISSION/TREATMENT AUTHORIZATION AND CONSENT

I hereby consent to admission/diagnostic procedure at Affiliated Endoscopy Center for outpatient treatment. My doctor had explained to me the necessity for this admission, the course of treatment, alternatives, advantage and possible complications. With this knowledge, I voluntarily consent to the rendering of such care including diagnostic procedures, and medical treatment by authorized agents of the Affiliated Endoscopy Center, by its medical staff, or either designees, as may in their Professional judgment to be deemed necessary or beneficial. If an employee is exposed to my blood and or any body fluids I give consent to have an HIV, Hepatitis B and Hepatitis C blood test.

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 deductibles, 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.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to *Affiliated Endoscopy Services of Clifton*, 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 Physician 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 laws 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 *Affiliated Endoscopy Services of Clifton* has an ownership interest in *Affiliated Endoscopy Services of Clifton.* 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 *Affiliated Endoscopy Services of Clifton.*

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/ADVANCE DIRECTIVES INFORMATION

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

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Affiliated Endoscopy Center and / or Physician performing my procedure today to communicate information regarding my procedure/ results of my procedure/billing to/with:

- My spouse/family member/ other Name(s): _____ _____Patient initials
- Leave a message on my answering machine: Yes _____ No _____ _____Patient initials

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

Signature of Patient or Responsible Party

Print name

Relationship to Patient

Date Signed