

CONSENT FOR TREATMENT

1. The undersigned hereby certifies and acknowledges the following:
I understand the physician services are provided by my admitting physician, and that I will be billed by the physician for their services to me. I will also be billed by the Endoscopy center for services provide by the facility. Pathology fees may be filled separately depending upon my carrier.
2. I believe that I, or the patient being treated, require medical treatment and do hereby voluntarily consent to such treatments including anesthesia and/or sedation and laboratory diagnostic procedures, pertinent physical examination or other treatment as may be considered necessary or advisable by my admitting physician, or other Center personnel, including transfer to the nearest hospital for emergency treatment if necessary.
3. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been given me by anyone as to the results that may be obtained from such medical treatment.

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, but are 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.

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 of 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 other third-party payer and certify that the information given with regard to insurance coverage is correct.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Center, my admitting physician, or other physicians who render service to me. I understand and agree to be financially responsible to 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 other third-party payer and certify that the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

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

The Center, it agents, and employees, my attending physician, and other physicians who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

DISCLOSURE AGREEMENT

I have been informed by the staff that the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the above facility.

CERTIFICATE

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

Initials _____

I hereby acknowledge that a copy of the Notice of Privacy Practices for the ENDOSCOPY CENTER OF WASHINGTON DC (NPP Version 1A) has been made available to me. I have the right to obtain a paper copy upon request.

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

Time

DOB: «PBDAY» ACCT# «PACCT»
Dr. «PPFNAME» «PPLNAME» «BKVISITTYPE»

«PLNAME», «PFNAME»