Space Coast Endoscopy Center

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Space Coast Endoscopy Center's and/or physician's charges and/or anesthesia charges, the Center and/or physician's which render service to me are authorized to submit a claim for payment to my insurance carriers(s). The Center, physician's office, anesthesia and/or pathology providers 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 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. I am aware that I may receive a separate bill should there be any pathology performed from the pathology companies.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Space Coast Endoscopy 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 physician(s) 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 Space Coast Endoscopy Center may have an ownership interest in Space Coast Endoscopy 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 Space Coast Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have provided 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 policies pertaining to Advance Directives prior to the procedure. Information regarding Advance Directives along with official State documents has been offered to me upon request.

STATEMENT OF LIMITATION

Space Coast Endoscopy Center respects the rights of patients to make informed decisions regarding their care. If a patient becomes unable to make a decision regarding his/her own care the Center staff will consult the Advance Directives, medical power of attorney, or patient representative or surrogate, if available. Due to the outpatient nature of an ambulatory surgery center, this Center has adopted the position that an ambulatory surgery center is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this center; the personnel at the Center will initiate the resuscitative or other stabilizing measures and transfer the patient to an acute care hospital. At the acute care hospital, further treatment decisions will be made. If copies of the patient's Advance Directives have been provided to the surgery Center, copies will be sent with the patient to the hospital. If the patient has Advance Directives which have been provided to the Center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

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**

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize Space Coast Endoscopy Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

_____ _____ _____

Patient Signature Date Signed Printed Name

_____ _____ _____

Parent/Guardian Signature (if patient is a minor) Date Signed Printed Name

Contact Information:

Mobile Phone Number: _____ Email address:_____