MULTIPLE AUTHORIZATION FORM

Advanced Endoscopy and Surgical 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. I understand that I may also receive bills from the physician, anesthesia provider and pathology lab separate from the center. All service providers independently bill for services rendered.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Advanced Endoscopy and Surgical 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 balances 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 the date of the procedure that the physicians who perform procedures/services at Advanced Endoscopy and Surgical Center may have an ownership interest 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 Advanced Endoscopy and Surgical Center.

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Advanced Endoscopy and Surgical Center has been made available to me. I have the right to obtain a paper copy upon request.

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 the procedure. I have also received information regarding Advanced Endoscopy and Surgical Center policies pertaining to ADVANCED DIRECTIVES prior to the procedure. ADVANCED DIRECTIVES will not be honored within the Center.

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Advanced Endoscopy & Surgical Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with my stated spouse/family member/other. I have also given the center my notice as to permissions for voice mail.

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

<PATIENT_SIG>