FORM-MULTIPLE AUTHORIZATION

University Endoscopy 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.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to University Endoscopy Center, my admitting physician, AmSurg Cincinnati Anesthesia, or other providers 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, AmSurg Cincinnati Anesthesia, my admitting physician, or other providers 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

The center is owned, in part, by University of Cincinnati Physician Company LLC. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations

***SIGNING BELOW CONFIRMS RECEIPT OF PATIENT BILL OF RIGHTS AND DISCLOSURE**

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 procedure. I have also received information regarding University Endoscopy Center policies pertaining to ADVANCED DIRECTIVES prior to the date of the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

Do you have an Advanced Directives for Healthcare? Yes or No (Circle)
Did the patient bring a copy to the University Endoscopy Center? Yes or No (Circle)
The University Endoscopy Center cannot honor Advanced Directives unless the patient provides a copy to the center.
If provided, copy is placed in patient's medical record.

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**