AGREEMENTS SIGNATURE FORM

TAMPA BAY ENDOSCOPY CENTER

Financial Policy

- If you have insurance, we will help you receive maximum benefits by filing a claim for you. If you have a deductible, co-pay, or co-insurance, payment arrangements must be made prior to surgery. You are expected to follow the rules of your carrier in obtaining pre-authorization or referrals. Any non-covered amounts will be the patient's responsibility and billed to the responsible party.
- If Medicare/Medicaid, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare/Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for facility services. I understand that I am responsible for my health insurance deductibles and co-insurance.
- If you do not have insurance, payment arrangements must be made prior to surgery. If requested, an estimated price quote of charges for your procedure will be given. These quotes are based on averages and may vary significantly from actual charges because every patient's surgery is different. These quotes will not include any physician fees or services.
- The patient is responsible for all charges incurred at the Center. A bill from the Center for the use of the facility will be sent to the patient and/or the patient's responsible party. The charges on the bill cover the use of the facilities. These charges do not include any professional physician fees, pathology, radiology, or pre-operative testing fees.
- Any returned check fees and/or collection fees will be the patient's responsibility.

Assignment of Insurance Benefits

- I hereby assign benefits to be paid on my behalf.
- I understand and agree to be financially responsible for charges not paid within a reasonable period of time by insurance or third party payor and certify that the information given with regard to insurance coverage is correct.

Financial Agreement

I agree that payment for all charges incurred are the primary responsibility of the patient or the patient's responsible party; I authorize the Center or its agent to verify the patient's insurance coverage and employment.

Disclosure Agreement

I have been informed that the physician who is rendering services to me (may/may not) have ownership interest in the Center. I have been given the option to be treated at another facility, which I have declined. I choose to be treated at the above referenced facility.

Certificate

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms. I also understand that a photocopy of this release is as valid as the original. This agreement is valid for the duration of the claims and appeals process, but not to exceed two years.

_____ Date: _____

Signature of Patient or Legal Guardian or Authorized Representative

_____ Time: _____

Relationship to Patient