AMBULATORY ENDOSCOPY CENTER OF MARYLAND
PATIENT NOTIFICATIONS

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the charges related to my care at the Ambulatory Endoscopy Center of Maryland ("the Center"), the Center, physicians, and/or other providers (including anesthesia personnel associated with Corridor Anesthesia, LLC) who render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, and/or Corridor Anesthesia, LLC 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. The Center will expect payment of deductibles, co-pays, and co-insurance at the time of service.

I understand that I may receive up to four (4) separate statements for my procedure, including statements from the Ambulatory Endoscopy Center of Maryland (facility fee), Capital Digestive Care (physician's fee), Corridor Anesthesia (anesthesia fee), and Laboratory/Pathology fee (if specimens are taken during the procedure). 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 the Ambulatory Endoscopy Center of Maryland, my physician, and/or other providers (including anesthesia personnel associated with Corridor Anesthesia, LLC) 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 physician, and/or other providers who render service related to charges not paid 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 physician, and/or other providers (including anesthesia personnel associated with Corridor Anesthesia, LLC) 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 my surgery/procedure that the physicians who perform procedures/services at the Ambulatory Endoscopy Center of Maryland may have an ownership interest in the Ambulatory Endoscopy Center of Maryland. A list is available outlining physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility, which I have declined. I wish to have my procedure/services performed at the Ambulatory Endoscopy Center of Maryland.

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.

PERSONAL VALUABLES

It is understood and agreed that all money and valuables should be given to the patient's responsible companion for safekeeping. The Center shall not be liable for the loss or damage to any money, jewelry, documents or other articles of unusual value.

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 ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

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