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, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carriers. 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, excluding labs. Labs will be billed to the patients directly.

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 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 my surgery/procedure that the physicians who perform procedures/services at the Center may have an ownership interest in Space Coast Endoscopy 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 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 surgery/procedure. I have also received information regarding Space Coast Endoscopy Center policies pertaining to Advanced Directives prior to the procedure. Information regarding Advanced Directives along with official State documents have 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 decisions regarding his/her own care, 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 that in the absence of an applicable properly executed Advanced Directive, if there is a deterioration in the patient's condition during treatment at the Center, the personnel at the Center will initiate 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 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	**Witness**
Relationship to Patient	**Date Signed**