ABILENE ENDOSCOPY CENTER
1249 AMBLER
ABILENE, TEXAS 79601

Financial Agreement

If you have insurance, we will help you receive maximum benefits by filing for you, however, we will expect payment of copays, coinsurance and deductibles at the time of service.

The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance pays in accordance with the policy benefits. Any fees related to collection of delinquent accounts will be borne by the patient.

Assignments of Insurance Benefits

I hereby assign benefits to be paid, on my behalf, to the Practice/Center who renders service to me.

I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third-party payer and certify that the information given with regard to insurance coverage is correct.

Release of Information

I authorize the Practice/Center rendering service to release all or part of my medical records then required for the submission of any insurance claims for payment of services rendered by the Practice/Center.

The Practice/Center, it's agents, servants and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

Disclosure Agreement

I have been informed by the Practice/Center that the physician who is rendering services has an ownership interest in the referenced facility (Abilene Endoscopy Center). The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the referenced facility.

Certificate

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

_____	_____
Signature	Signature of Guardian/Responsible party
_____	_____
Date/Time	Date/Time
_____	_____
Print Name	Relationship to patient