



PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

1. FINANCIAL AGREEMENT/PAYMENT RESPONSIBILITY

Initials

I have read and understood the terms of the Facility Financial Policy. I understand that claims are filed to my insurance company as a courtesy and that I am at all times financially responsible to PEC for charges not paid and/or not covered by my insurance company. It is my responsibility to notify PEC of any changes in my health insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. If a claim is denied for any reason, I am responsible for the entire bill or balance of the bill as determined by PEC and/or my health insurance company. I UNDERSTAND THAT IT IS MY RESPONSIBILITY CO-PAY, DEDUCTIBLE, CO-INSURANCE AT THE TIME OF SERVICE AND TO PAY ANY BALANCES NOT PAID FOR BY MY INSURANCE COMPANY WITHIN A REASONABLE TIME PERIOD NOT TO EXCEED 45 DAYS FROM THE DATE OF SERVICE.

2. ASSIGNMENT OF INSURANCE BENEFITS

Initials

I authorize the payment of medical benefits to be made on my behalf directly to PEC for any services provided to me by the endoscopy center. This assignment of benefits shall remain in effect, even if my health insurance plan changes.

3. AUTHORIZATION TO RELEASE INFORMATION

Initials

I hereby authorize PEC to release any and all of my records to my insurance company, or any other third party payer legally responsible for the payment of my medical expenses. I understand that it may be necessary to release this information for claim processing and payment for services rendered by PEC. This information may include but not limited to information about communicable diseases, such as HIV/AIDS, psychiatry, drug and/or alcohol abuse. This general release and authorization shall remain in effect until revoked by me in writing.

5. NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

Initials

I have received, read and understand PEC's Notice of Privacy Practices. I understand that some of my information may be used to carry out treatment, payment and normal healthcare operations of PEC.

6. STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT

Initials

I certify that I have received and read PEC's Statement of Patient Rights and Responsibilities.

Medicare Patients Only:

4. MEDICARE / MEDICAID

Initials

I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize PEC to release to Center for Medicare and Medicaid Services (CMS), or its intermediaries or carriers, any information needed for processing this or a related Medicare/Medicaid claim. I hereby request that payment of authorized Medicare benefits be made on my behalf directly to PEC for any services rendered to me by PEC.

Patient Name: _____

Witness Signature: _____

Patient Signature: _____

Printed Witness Name: _____

Date: _____

Date: _____

Representative Signature (if patient is unable to sign): _____

Printed Name of Representative: _____ Relationship to Patient: _____