endoscopy center of niagara

6930 Williams Road | Niagara Falls, NY 14304 | 716-284-3264

Patient Name:
MRN:
DOB:
Gender:
Date:
Physician:
Procedure

PATIENT CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

For use and/or disclosure of protected health information to carry out treatment, payment, and healthcare operations

<Patient name> hereby states that by signing this Consent, I agree and acknowledge the following:

1. The Notice of Privacy Practices ("Privacy Notice") for Endoscopy Center of Niagara, LLC (the "Center") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") by the Center. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The Center reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Center:
   a. A postcard mailed to me at the address provided by me; and/or
   b. Telephoning my home and leaving a message on my answering machine.

3. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Center will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

<Patient_Sig> <Witness_Sig>

FOR USE BY THE CENTER ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowlegement, and the reasons why the acknowledgement was not obtained:

Signature of Center representative:_____

Printed Name of Center representative:_____

Date:_____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The center was established to meet the special needs of patients with gastrointestinal complaints or diseases. It is an "Ambulatory Surgery Center" specially designed for the practice of gastroenterology - no other medical procedures are performed here. The physicians providing services at our facility are all gastroenterologists. Our clinical staff are trained professionals experienced in caring for our patients. The mission of the center is to provide quality care in a specialized outpatient setting. Each patient will have our utmost careful and personalized attention.

By law, we are required to notify you that some of the physicians performing procedures here have a direct financial interest / ownership in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The fee that we charge for our services is intended to cover the cost of operating this facility including equipment, staff, rent, supplies, etc. You will also receive a separate bill from the physician's office for their professional services, a separate bill for anesthesia and possibly the laboratory for any pathology services. The facility, laboratory and physicians' professional offices are all separate legal entities providing separate and distinct services.

2. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process as long as we have the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.

3. All co-payments and deductibles are due and collected at the time of service as required by the contract between the patient, the insurer and our center.

4. Some insurers require precertification, preauthorization, or a written referral. It is the patient's responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. We cannot accept responsibility for a disputed claim. If your insurance company denies the claim for any reason or holds payment, you are ultimately responsible for the balance due.

5. We recognize that there may be times when full payment is not possible. Patients covered by insurers that our center has not contracted with or any patients without insurance are expected to pay a minimum of 50% of the procedure fee at the time of service and a minimum of one third of the remaining balance over three months following the date of service.

6. If you are having financial difficulty or have any questions, please contact our billing office to discuss your account. Payments are expected to be paid monthly and will be monitored. Non-payment of accounts after three months may result in referral to an outside collection agency that could impact the patient's credit record.

I received a copy / reviewed the Patient's Rights and Responsibilities prior to the procedure.

Advance Directive: <AD> Copy of advance directive will be placed in medical record. Advance material information is also available at the registration desk.

I have read the above and understand and agree to the terms set forth in this acknowledgement of financial responsibility and that regardless of any insurance coverage I may have, I am ultimately

responsible for payment of my account with the center.

Exceptions / Additions to any of the above: <None>

<Patient_Sig> <Witness_Sig>
Patient Name: <Patient name>

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