GEORGIA ENDOSCOPY CENTER, LLC
AND
ENDOSCOPY CONSULTANTS, LLC
PATIENT INFORMATION

I request that payment of authorized benefits be made to **GEORGIA ENDOSCOPY CENTER, LLC (GEC)** and/or **ENDOSCOPY CONSULTANTS, LLC (EC).** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug anc alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any healtl care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order tc treat me.

I hereby assign and authorize payment to **GEC** and/or **EC** and for all medical and/or surgical benefits, including major medica policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fee: and charges incurred by me or anyone on my behalf. I understand that any up front out of pocket costs quoted are an estimate onl and that additional procedures, biopsies, tissue removal and anesthesia costs will result in additional personal financia responsibility. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directl reimbursed to **GEC** and/or **EC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered a: effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

SIGNATURE ______________________________ **Date** ______________

RELATIONSHIP TO PATIENT ______________________________

ALTERNATIVE CONTACT AUTHORIZATION

I ☐ **DO** ☐ **DO NOT** authorize **GEC** and/or **EC** to contact me or leave messages.
Date:______________ Initials:______________

I ☐ **DO** ☐ **DO NOT** authorize **GEC** and/or **EC** to discuss my appointments, medical evaluation, treatment and results to relatives or other persons as indicated:

Authorized person(s)/relationship: ______________________ Initials :______________Date: ______________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **"NOTICE OF PRIVACY PRACTICES"** for my records.

Signature:______________________________Date:__

ADVANCE DIRECTIVES AND PATIENT'S RIGHTS & RESPONSIBILITIES

I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I alsc acknowledge that I ☐ **DO** ☐ **DO NOT** have such Directives. If I do not have such Directives at this time, but establish them at a later date, I will provide the Center with a copy.

Initials:________ Date:________Instructions/location of directives if not provided at this time: ______________________

I acknowledge that I have been provided the Rights and Responsibilities that include the notification of physician ownership, the facility policy on Advance Directives, and how to file a complaint and/or grievance.

Signature:______________________________ Date:______________________

Updated 12-23-14