Island Endoscopy Center, LLC

1175 MONTAUK HIGHWAY SUITE 1
WEST ISLIP, NY 11795
PHONE# (631) 376-0001

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have scheduled a procedure at ISLAND ENDOSCOPY CENTER, LLC. I have been given a written copy of the instructions. The instructions include details of my responsibilities as a patient in the Endoscopy Center. I have been made aware of the Legal Ownership of the Center, Billing Practices, Patient's Bill of Rights, Health Care proxy and Privacy Practice. I have been informed that I must bring someone with me for my procedure. I will not be able to drive home. I understand if I do not bring an escort that can drive I will not be able to have the procedure.

I know that if I have any further questions I may call the Endoscopy Center during the hours of 8-4 Monday - Friday.

______________________ ______________________
Date of Procedure Date of receiving Notice

______________________ ______________________
Name of Patient Date of Birth

______________________ ______________________
Day Time Phone # Evening Phone #

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Race Ethnicity Last four of SS#

______________________ ______________________
Signature of Patient Surgeon

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Primary Insurance Carrier