ISLAND
ENDOSCOPY
CENTER, LLC

1175 MONTAUK HIGHWAY, SUITE 1
WEST ISLIP, NY 11795
TEL (631) 376-0001 FAX (631) 376-0003

PATIENT ACKNOWLEDGEMENT / FINANCIAL POLICY / ASSIGNMENT OF BENEFITS CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Thank you for choosing Island Endoscopy Center, LLC for your procedure. Island Endoscopy Center is an Article 28 Ambulatory Surgery Center accredited by The Joint Commission. Please take the time to read through the items below. If you have questions, please feel free to contact either your physician or the center.

PATIENT ACKNOWLEDGEMENT

I acknowledge that my gastroenterologist recommends that I undergo a procedure and that it is my responsibility to schedule this procedure with my physician's office. I have been given written preparation instructions, which include details of my responsibilities as a patient in the Endoscopy Center. Legal Ownership of the Center is equally divided between Rajkumar Mariwalla M.D. and Noel D'Silva M.D. Information regarding Billing Practices, Patient's Bill of Rights, and Privacy Practices has been made available to me. The policy of the center regarding health care proxy is that we will provide full resuscitation and transport to the nearest hospital. I understand that I have the right to have my medical procedure performed at another health care facility. By referring me to Island Endoscopy Center, it is the physician's belief that my medical needs will be best served in the most convenient and efficient way possible.

I have been informed that a responsible adult must accompany me on the day of my procedure and escort me home upon discharge. I understand that I cannot drive myself or take public transportation home alone. I understand that if I am not accompanied by an escort I will not be able to have the procedure.

FINANCIAL POLICY

The center and its anesthesiologists are in-network with many health insurance plans. Your physician, the center, anesthesiologist, and pathologist (if applicable) are independent providers and will submit separate claims to your carrier. If any provider involved in your care is out of your insurance carrier's network the carrier will be contacted to pre-authorize the procedure and work with your health plan to negotiate an acceptable payment on your behalf to minimize your out of pocket responsibility.

You may be billed for any applicable in-network copay, deductible, or co-insurance. Dependent on your carrier and benefit plan, this information will be outlined on the insurance card or can be obtained on the insurance company's website or by calling the member services' number on your insurance card. If your carrier issues payment directly to you, you will be responsible for forwarding payment to the center.

All professional and facility services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurances. Any remaining balances after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed directly to you.

ASSIGNMENT OF BENEFITS

I hereby assign benefits to be paid, on my behalf, to Island Endoscopy Center, LLC for services rendered to me. I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or third-party payers. In the event my insurance carrier pays me directly, I will forward payment immediately to Island Endoscopy Center, LLC along with the explanation of benefits from my insurance carrier. I certify that the information given with regard to insurance coverage is true and accurate to the best of my knowledge.

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I authorize Island Endoscopy Center, LLC to release any or all of my medical records when required for the submission of any insurance claims for payment for services rendered by the Island Endoscopy Center, LLC. Island Endoscopy Center, LLC, its agents and contracted providers 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. This authorization is valid for the release of medical information to all insurance carriers.

I permit a copy of this authorization to be used in place of the original.

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

As the provider of healthcare services, Island Endoscopy Center, LLC is authorized to release any protected health information required for medical treatment, payment for services rendered or for other healthcare operations of the Center, or the healthcare operations of a contracted medical provider, if applicable. Before information is released to parties other than for treatment, payment of your account or for healthcare operations, the Center will require specific authorization from you.

With my consent, Island Endoscopy Center, LLC may call my home, or other designated location, and leave a message or may mail to my home, or other designated location, in reference to any items that assist the Center in carrying out healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including pathology results among others.

I have the right to request Island Endoscopy Center, LLC restrict how it uses or discloses my protected health information; however, the center is not required to agree to all requested restrictions, but if it does, is bound by this agreement.

By signing below, I acknowledge that the Notice of Privacy Practices has been made available to me or I can obtain a copy on the center's website (www.IslandEndoscopy.com). I have the right to restrict uses and disclosures of health information as it pertains to treatment, payment, and healthcare operations.

I authorize the staff to leave medical information pertaining to my care by the following methods:

Home messaging Yes_____ No_____ Cellular messaging Yes_____ No _____

Please list the names of whom we can leave messages with:

Name/ Relationship_____ Name/ Relationship_____

Name of Patient_____ Date of Birth_____ Physician_____

Patient Signature or Legal Guardian _____ Relationship to patient _____

Date of Notice _____