PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology --- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention.

Please be aware that some of the physicians performing procedures may have a direct financial ownership interest 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 covers the non-professional component of your procedure also known as the "technical" or "facility" fee which includes 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, anesthesia services, and possibly the laboratory for any pathology services. The facility, laboratory, and physicians' professional office are all separate legal entities providing separate and distinct services.

2. As a courtesy to our patient's, 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. We expect all known co-payments to be paid at the time of service or as required by the contract between the patient, the insurer, and our center. We reserve the right to collect co-pays, deductibles, and coinsurance upon notification by the insurer.

4. Some insurers require pre-certification, pre-authorization, 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. If your insurance denies the claim, or holds payment, you may be ultimately responsible for the balance.

5. If you have any questions related to the balance, please contact our Billing Office to discuss your account. Non-payment will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

Patient has Advance Directive ☐ YES ☐ NO

Patient Advance Directive provided to the Center and placed in Medical Record ☐ YES ☐ NO

Advance Directive information was provided to the patient by the center. ☐ YES ☐ NO

Prior to the initiation of the procedure, the patient received a brochure and verbal information outlining the Patient's Rights and Responsibilities and the facility's policy on advance directives. ☐ YES ☐ NO

Authorization to Release Information: I hereby authorize Garden State Endoscopy & Surgery Center, to release any and all information necessary for the billing and processing of the account for services rendered.

I understand I should not bring any valuables to Garden State Endoscopy & Surgery Center and that the center is not liable for the theft or loss of valuables.

Assignment of Insurance Benefits: I hereby authorize payment to Garden State Endoscopy & Surgery Center insurance benefits, otherwise payable to me, for this service. Payment to Garden State Endoscopy & Surgery Center shall not exceed the balance due for services rendered.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that I am financially responsible to the center for charges not covered by this assignment.

Patient's Name (printed):_____

PATIENT SIGNATURE: _____

CENTER REPRESENTATIVE SIGNATURE: _____