HAMILTON ENDOSCOPY AND SURGERY CENTER

IMPORTANT PATIENT INFORMATION

RELEASE OF MEDICAL RECORDS

I authorize the center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the center is permitted to release such information under applicable laws. In the event that I am transferred to or admitted to a hospital post procedure or require emergency room care within 24 hours post procedure, I authorize the center to obtain a copy of the hospital discharge summary.

IDENTITY THEFT

To prevent identity theft, you will be asked to provide photo identification at the time of admission (e.g. valid driver's license) along with your insurance card. The receptionist at the center will photocopy the identification and insurance card and place a copy in your medical record.

FINANCIAL ARRANGEMENTS

I authorize and direct my insurer or payor to pay directly to the above center any and all benefits up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the facility. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the center for any amounts not covered by insurance. Furthermore, I understand that my insurer or payor may require certain health services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the center with respect to the services that I choose to receive notwithstanding that my health insurer or payor has refused to give preauthorization for all or any portion of my services.

PRE-CERTIFICATION

Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services.

FACILITY CHARGE

When your procedure is performed at the above Surgical Center, there will be a facility fee. There is a charge for the use of the procedure room for your procedure. Fees will vary according to the type of procedure that is being performed. Patient responsibility is dependent upon individual insurance plans.

COLLECTION EXPENSES (MEDICARE/MEDICAID EXCLUDED)

Should my account with the Surgery Center be referred to an attorney or outside agency for collection I will pay all reasonable collection expenses, including attorney fees, associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

PROFESSIONAL FEES

These are the fees that are billed by your physician for his services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan.

For questions regarding your physician or facility bill please contact HGI Billing: 609-581-4820

Anesthesia

A certified anesthesiologist and board certified nurse anesthetist will be participating in your procedure in order to provide comfort and safety. This service will be billed to your insurance company. For questions pertaining to your anesthesia bill please contact HGI Anesthesia Billing at 1-800-477-7577

Pathology

If a biopsy is required during the course of your procedure a tissue sample will be sent to the laboratory to be analyzed by a pathologist. You may receive a separate bill from the pathologist. For questions pertaining to your pathology bill please contact HGI Billing at 609-581-4820

ADVANCE DIRECTIVE/LIVING WILL/POLST

It is the policy of Hamilton Endoscopy and Surgery Center that, regardless of the contents of an Advance Directive/POLST or instructions from a healthcare surrogate or Power of Attorney that if an adverse event occurs during treatment the center personnel will initiate resuscitative or other stabilizing measures and transfer the patient to an acute c are hospital for further evaluation.

PATIENT RIGHTS /HIPAA/ ADVANCE DIRECTIVE/ DISCLOSURE OF OWNERSHIP

I acknowledge that I have been given written notification of the following:

- NJ Patient Bill of Rights and responsibilities
- a copy of the HIPAA privacy regulations
- Facility policy on Advance Directives
- Disclosure of ownership

ACKNOWLEDGEMENT OF DRIVING RISKS

I have been informed by HGI on behalf of HESC that I should not drive for at least 24 hours after completion of my procedure. **A responsible adult companion is required upon discharge from HESC for all patients who have received anesthesia**. Only patients who do not receive anesthesia/sedation and who meet the discharge criteria may be discharged unescorted.

PATIENT SIGNATURE

The undersigned certifies that this form has been fully explained to him/her and the undersigned is satisfied that he/she understands its contents and significance.

_____	_____	_____
Patient Signature	Patient printed name	Date