Greenbelt Endoscopy Center

9821 Greenbelt Road, Suite 103
Lanham, Maryland 20706
Ph: (301) 552-1801
Fax: (301) 552-2695
www.greenbeltendoscopy.com

Patient Name: _____ Sex: _____ Date of Birth: _____

PATIENT AUTHORIZATION FORM 01/2016

PART A: The policyholder, hereby authorize any benefits due to me / my dependent under this policy to be paid in accordance with this assignment in consideration of medical, and or anesthesia services rendered to my dependent or me on this visit.

I hereby assign and transfer any benefits under the above-described contract as follows insofar as they are necessary to cover the expense:

I have verified that my personal information and health insurance information are correct and current. I understand that GEC is required to provide my information to the insurance company at the time of the claim is submitted. The insurance company may reject the claim due to incomplete or incorrect personal information. If the claim is rejected as a result of invalid or missing personal information, I will be responsible to pay the full amount of the visit.

A photo static copy of this assignment shall be considered effective and valid as the original. Service Center Benefits to: Greenbelt Endoscopy Center, 9821 Greenbelt Road, Suite 103, Lanham, MD 20706 IRS # 52-1950078.

PART B
This charge is a flat fee for the use of the Endoscopy Center. It includes the procedure room. Pre procedure and recovery room care where a Registered Nurse (RN) is in attendance. All supplies are included. We do not itemize each cost as we wish to keep the expense to a minimum. The Endoscopy Center will collect from the patient the balance not paid by the insurance carriers.

PHYSICIAN'S FEE, ANESTHESIA SERVICES, AND OUTSIDE LABORATORY FEE ARE NOT INCLUDED IN THESE CHARGES. THESE TWO PARTIES WILL SUBMIT THEIR OWN CLAIMS FOR THEIR PROVIDED SERVICES AND GEC IS NOT RESPONSIBLE FOR THEIR CHARGES.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF "HIPAA OMNIBUS RULE NOTICE OF PRIVACY PRACTICES" AND CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT/ PAYMENT

I hereby authorize Greenbelt Endoscopy Center to use and/or disclose my health information that specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Greenbelt Endoscopy Center can refuse to treat me.

I understand that in the event that it becomes necessary for these medical records to be released to other health care practitioners, I will have to grant permission in advance for each type of "non-routine" use or disclosure.

I understand that I may revoke this consent at any time by notifying Greenbelt Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Greenbelt Endoscopy Center took before receiving my revocation.

I have received a "HIPAA Omnibus Rule Notice of Privacy Practices" version 0913 that Greenbelt Endoscopy Center has prepared for me. This notice fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I have reviewed such Notice prior to signing this consent. A copy of this signed, dated document shall be as effective as the original.

I understand that Greenbelt Endoscopy Center reserves the right to change his/her privacy practices and that I can obtain such notice upon request.

I fully understand and accept the terms of this consent

Procedure type: _____

Co-Payment received: _____

FOR CAPSULE ENDOSCOPY PATIENT ONLY

Because this procedure requires the patient to carry part of the instrument for a period of time, a **$200.00 retaining fee** must be submitted. You can choose to pay this retaining fee by credit card, check, or cash. This retaining fee will be reimbursed once the equipment is returned to the Center.

In the event there is a delay in returning the equipment or the equipment is lost, Greenbelt Endoscopy Center reserves the right to withhold the equipment retaining fee and collect from the patient for the lost of equipment as per current market value.

Retaining fee collected from patient: _____ (please specify payment method e.g cash, check, credit card, or waived)

_____

Patient Signature/Legal Guardian

_____

Witness

_____

Date