**Columbia Gastrointestinal Endoscopy Center**

## FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays, and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Columbia Gastrointestinal Endoscopy Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

## RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

## DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Columbia Gastrointestinal Endoscopy Center may have an ownership interest in Columbia Gastrointestinal Endoscopy Center. I have been advised that I will be provided a list of physicians who have a financial interest or ownership in the Center upon request. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Columbia Gastrointestinal Endoscopy Center.

## CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the center is correct.

## Email/Text/Automated Communication Informed Consent

I hereby consent and authorize Columbia Gastrointestinal Endoscopy Center and any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature | Date Signed | Printed Name

Parent/Guardian Signature (if patient is a minor) | Date Signed | Printed Name

**Contact Information**:
Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from Columbia Gastrointestinal Endoscopy Center, you may unsubscribe by replying and entering “Unsubscribe.” If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

## PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party | Print Name

_____ _____
Relationship to Patient | Date Signed