1. CONSENT TO TREATMENT

As a patient of The Colonoscopy Center Inc. (The Center), I agree, request and authorize the surgeons, their assistants or designees and/or allied health professionals to administer such treatment to me as is necessary. Necessary treatment includes but is not limited to services, care, diagnostic procedures, medical treatments, pathology services and radiology services as the surgeon(s) or other health care providers(s) deems reasonable and necessary. I acknowledge that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

2. MEDICARE PATIENTS ONLY – ASSIGNMENT AND CERTIFICATION

I request payment of authorized Medicare benefits on my behalf for any services furnished to me by or in The Center and assign payment to The Center. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to The Center is true, accurate and complete.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT.

I hereby assign to and direct payment directly to The Center, for services provided by The Center and its employees or others working under contract or arrangement with The Center, all coverage or other benefits available under any government program, any insurance policy or plan, any other benefit program, and any law allowing recovery against third parties, and I direct that all benefits be paid directly to The Center. I further assign to and direct payment directly to all surgeons providing services to me at The Center, and billing separately for their services, all coverage and benefits available for the services of such surgeons and their employees. I agree that The Center and the surgeons may discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payment or other sources may be applied to any other account now or later owed by me or the undersigned. The benefits assigned include, but are not limited to, all benefits for all medical and hospitalization insurance, liability or accident insurance, disability or loss-of-time insurance, Medicare, Medicaid and CHAMPUS, benefits payable by alternative delivery systems such as HMOs and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is, entitled because of any judgment, settlement, or other claim or cause of action for damages against any person or organization if I was or am injured. This assignment may not be revoked.

3. FINANCIAL AGREEMENT

If I do not have insurance I understand I must pay at the time of service or make arrangements with The Center. I understand The Center has no duty to bill any insurer or other benefit provider however has agreed to file claims on my behalf. I will make available my current insurance and policy holder information at each visit. I will authorize payment directly to The Center. If my insurance requires co-payments, I must pay that amount at the time of service. The Center will send me monthly statements so I know my insurance has made payment and my responsibility for remaining balance. Payment is due upon receipt of the monthly statement. I may be billed by surgeons or facilities for other services such as lab services or the reading of radiology images. I am responsible for knowing the details and requirements of my insurance plan. If my medical care is the result of a work related injury, my claim will either be sent directly to me or my employer for them to pay directly or to forward to their worker's compensation carrier. It is my responsibility to complete any necessary forms to allow The Center to release information to my employer**.** Accounts not paid in full within 30 days are considered past due. If payments are not received within The Center's established collection guidelines, my account may be placed with a collection agency and/or placed on a "cash basis" or eventually terminated from care for nonpayment. The Center's no-show policy states if a patient does not cancel an appointment within 1 hour of their scheduled time or arrives more than 15 minutes late will be considered a No Show. Patients are allowed 3 no shows within a 12 month period before care maybe terminated. I agree to promptly and fully pay all charges for services and supplies provided by The Center, its surgeons, and others providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the spouse of the patient, the parent of a minor patient, or the legal guardian of a patient, for payment of all such charges at the regular rates to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I understand that it is my responsibility to obtain any prior approvals required by an insurer, and to take all other steps to qualify for insurance coverage; I will determine whether my insurer requires pre-certification before I receive hospital services. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

4. RELEASE OF RESPONSIBILITY FOR PERSONAL PROPERTY

I understand that valuables and other personal property should be left at home or entrusted to a family member. I unconditionally release The Center from liability for loss or theft of personal property brought to The Center.

5. LEGAL RELATIONSHIP BETWEEN FACILITY AND SURGEON

I understand that surgeons providing services including surgery, radiology, pathology, anesthesiology, and other medicine services at The Center's facilities are independent contractors with the patient and are not employees or agents of The Center. As such, these various independent contractors may submit bills for the professional services they provide separate from the bill The Center may submit for technical services. Services provided by The Center personnel are provided to the patient pursuant to the general and special instructions of the patient's attending and consulting surgeons as described above.

6. NOTICE OF PRIVACY PRACTICES.
I was given The Center's Notice of Privacy Practices.

7. ADVANCE DIRECTIVES NOTICE ACKNOWLEDGEMENT
I acknowledge having received notice about The Center's policies on patient rights and advance directives, as well as notice of the surgeons ownership interests in The Center, prior to the date of my procedure at The Center. I acknowledge having received written information about The Center's policies regarding my rights to accept or refuse medical treatment and to formulate advance directives in the form of the documents entitled Patient Bill of Rights and Advance Directives Policy. I understand that the formulation of an advance directive is not required as a condition of treatment at this medical facility.

a. _____ I have a written Health Care Directive (Living Will), Durable Power of Attorney, or other Advance Directive and request a copy be included in my medical record for my surgeon to act upon.
b. _____ I do not have a written Advance Directive. I understand that I can request further information regarding Advance Directives from The Center.

8. SPECIALIZED TESTING
I understand that a test for the presence of the human immunodeficiency virus ("HIV") may be performed under this general conditions of admission when deemed appropriate by my health care provider, without my signing an additional consent for the specific purpose of HIV testing, I may refuse to have the HIV test performed unless I sign an additional consent. HIV is the virus which causes HIV infection that can eventually lead to Acquired Immunodeficiency Syndrome (AIDS). A person develops AIDS when the immune system becomes so damaged that it can no longer fight off disease and infection. Tests are available to determine the presence of HIV antibodies in the blood. A negative test result shows that HIV antibodies were not found in the blood. It does not mean that a person is free of HIV infection because the virus and the presence of HIV antibodies in the blood and the potential to infect someone else through sexual contact, sharing needles or syringes, or from mother to baby during pregnancy. The test does not tell whether you will eventually develop signs of illness related to HIV, nor if you do, how serious that illness might be.

9. CONTACT BY TELEPHONE
By providing The Center with my wireless / cell phone number, I hereby grant to The Center, and its agents or independent contractors, my consent to receive calls for billing and debt collection purposes on any and all wireless / cell phone numbers I list or use (even if unlisted).

10. I ACKNOWLEDGE RECEIPT OF THE COLONOSCOPY CENTER INC. CONDITIONS OF TREATMENT.
The undersigned certifies that he/she has read the foregoing and as the patient or as duly authorized signer on behalf of patient is authorized to execute the above and accept in terms. A copy of this document will be provided to patient or signer upon request.

_____ _____
Signature of Patient Date of Signature

_____ _____
Signature of Patient's Representative Time of Signing

_____ _____
Representative's Relationship to Patient Witness

If Patient is unable to sign, state reason:

_____

IT IS UNDERSTOOD THAT THIS AGREEMENT SHALL TAKE EFFECT UPON REGISTRATION EVEN THOUGH IT MAY BE SIGNED PRIOR THERETO. NOTE: A COPY OF THIS AGREEMENT IS TO BE DELIVERED TO THE PATIENT UPON REQUEST. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Colon and Rectal Surgery Inc.
The Colonoscopy Center Inc.

ELECTION AND CONSENT FOR PHYSICIAN-PATIENT COMMUNICATION

Colon and Rectal Surgery Inc. ("CRS")/The Colonoscopy Center Inc ("CCI") may disclose your relevant medical information to family members or others you designate who are involved in your care or payment for your care. To better understand your wishes and which family members and friends/others are involved in your care or payment for your care, we ask each patient to designate in writing those individuals who may receive information relating to your medical care or payment at CRS/CCI. By filling out the information below, we will be better able to serve you.

CRS/CCI may leave voicemail messages on the following information at the following numbers:

1. Home: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
2. Cell: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
3. Work: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment

CRS/CCI may leave the following information with the following people:

1. Spouse/Partner: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
2. Son/Daughter: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
3. Other: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment

Today's Visit:

For the purpose of today's visit, I am authorizing you to speak with the following person(s) regarding the outcome of today's procedure, discharge instructions, and plan of care.

_____

I understand that CRS/CCI does not and cannot guarantee the confidentiality of any voicemail messages or email communication and will not be liable for improper disclosure of confidential information and/or breaches in information caused by me or a third party.

I hereby voluntarily request and consent to communication with my physician and/or office personnel via the above designated communication methods.

_____ _____ _____
Signature of Patient Printed Name Date

If patient is a minor, has a legal guardian, or a power of attorney exists:

_____ _____ _____
Signature of Responsible Party Printed Name Date

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