Chevy Chase endoscopy center
5530 Wisconsin Avenue, Suite 500, Chevy Chase, MD 20815
301-654-8020

MULTIPLE AUTHORIZATION FORM

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 co-pays and co-insurance at the time of service.

I understand that I may receive up to four (4) separate statements for my procedure, including statements from the Chevy Chase Endoscopy Center (facility fee), Capital Digestive Care (physician's fee), Our Anesthesia Providers (anesthesia fee), and Laboratory/Pathology fee (if specimens are taken during the procedure). Self-pay patients are expected to pay the agreed upon balance at the time of service._____(initial)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to ASC CHEVY CHASE 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 ASC CHEVY CHASE ENDOSCOPY CENTER may have an ownership interest in ASC CHEVY CHASE ENDOSCOPY CENTER . 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 ASC CHEVY CHASE 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.

PATIENT RIGHTS/ADVANCED DIRECTIVE INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding ASC CHEVY CHASE ENDOSCOPY CENTER policies pertaining to ADVANCED DIRECTIVES prior to the date of the procedure. ADVANCED DIRECTIVES will not be honored within the Center.

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

_____ _____

Signature of Patient or Responsible Party **Print Name**

_____ _____

Relationship to Patient **Date Signed**