



PATIENT INFORMATION

PLEASE PRINT CLEARLY

Patient Name _____

Address _____

City, State, Zip _____

Primary Phone _____

Other Phone(s) _____

Birthdate / Age / Sex _____

Patient SSN _____

Employer _____

Marital Status _____

Emergency Contact Name _____

Relationship to Patient _____

Phone Number _____

Primary Care Physician First Name: _____ Last Name: _____ Phone #: _____

and/or

Referring Physician First Name: _____ Last Name: _____ Phone #: _____

Please specify both first and last name of each Physician

INSURANCE INFORMATION

| | Primary Insurance | Secondary Insurance |
|-------------------------|-------------------|---------------------|
| Insurance Name | _____ | _____ |
| Subscriber Name | _____ | _____ |
| Relationship to Patient | _____ | _____ |
| Subscriber SSN | _____ | _____ |
| Policy ID # | _____ | _____ |
| Group Number | _____ | _____ |

1. **CONSENT FOR PROCEDURES:** The undersigned consents to the procedures which may be performed during this visit, including treatment or services, and which may include but are not limited to laboratory procedures, anesthesia, or services rendered the patient under the general and special instructions of the patient's attending physician.
2. **NURSING CARE:** This center provides only general duty nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
3. **LEGAL RELATIONSHIP BETWEEN CENTER AND PHYSICIAN:** All physicians furnishing service to the patient are independent contractors with the patient and are not employees or agents of the center. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the center and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's attending physician to obtain the patient's informed consent, when required, for diagnostic or therapeutic procedures, or services rendered the patient under the general and special instructions of the physician.
4. **RELEASE OF INFORMATION:** See "Notice of Privacy Practices"
5. **PERSONAL VALUABLES:** It is understood and agreed that the center shall not be liable for the loss or damage to any money, jewelry, documents, garments or other articles of unusual value and small size, and shall not be liable for loss or damage to any other personal property. The liability of the center for loss of any personal property which is deposited with the center for safekeeping is limited to five hundred dollars (\$500.00) unless a written receipt for a greater amount has been obtained from the center by the patient.
6. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
7. **VERIFICATION AND ASSIGNMENT OF INSURANCE BENEFITS:** Any insurance benefits verified with the insurance carrier(s) related to this service do not constitute guarantee of payment. The patient/guarantor assumes responsibility for services which may be subject to policy exclusions, medical review denials or other reductions of payment from the verified amount. In the event the undersigned is entitled to center benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, or center benefits under the Disability Insurance code, said benefits are hereby assigned to center for application on patient's bill and it is agreed that the center may receipt for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment. The undersigned hereby authorizes any state, county, or other public agency and the officers, agents and employees thereof, to furnish Central California Endoscopy Center any and all personal and financial information relating to his/her eligibility for medical assistance and hereby releases, indemnifies and holds harmless said entities, persons and parties of all liability, cause or damage arising from such release of information.
8. **PATIENT RIGHTS, GRIEVANCES AND NOTIFICATION OF PHYSICIAN OWNERSHIP:** The undersigned agrees that they have received and read this notification prior to today's procedure. If the undersigned did not receive the notification one has been provided today.

The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. The undersigned understands that they may receive a copy of this form if they desire.

Signature: Patient/Spouse/Parent/Conservator/Guardian

(Indicate relationship)

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have been provided a copy of Central California Endoscopy Centers Notice of Privacy Practices to review, which discusses my protected health information. Specific requests are as follows: _____

Initials: _____

CONDITIONS OF ADMISSION