PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology --- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention.

Please be aware that some of the physicians performing procedures here have a direct financial ownership interest in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The fee that we charge for our services covers the non-professional component of your procedure also known as the "technical" or "facility" fee which includes the cost of operating this facility including equipment, staff, rent, supplies, etc. You will also receive a separate bill from the physician's office for their professional services, and possibly the laboratory for any pathology services. The facility, laboratory and physicians' professional office are all separate legal entities providing separate and distinct services.
2. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process as long as we have the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.
3. We expect all known co-payments and deductibles, except for those due under Medicare/Medicaid or other federal healthcare programs, to be paid at the time of service or as required by the contract between the patient, the insurer and our center. We reserve the right to collect co-pays, deductibles and coinsurance upon notification by the insurer.
4. Some insurers require pre-certification, preauthorization or a written referral. It is the patient's responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. If your insurance denies the claim, you may be ultimately responsible for the balance.
5. If you have any questions related to the balance, please contact our Billing Office to discuss your account. Non-payment will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

☐ Patient has Advance Directive ☐ Advance Directive information given to patient. ☐ N/A

☐ Patient has been given a Patient's Rights and Responsibilities brochure, Disclosure of Financial interests or ownership in the facility and notification of the facility's policy on advanced directives prior to the day of the procedure.

Authorization to release information: I hereby authorize Central Arizona Endoscopy, LLC to release any and all information necessary for the billing and processing of the account for services rendered.

Assignment of Insurance Benefits: I hereby authorize payment to Central Arizona, LLC insurance benefits, otherwise payable to me, for this service. Payment to Central Arizona, LLC shall not exceed the balance due for services rendered.

EPIX Anesthesia will bill my insurance carriers when applicable. I hereby authorize my insurance benefits to be paid directly to EPIX Anesthesia, and acknowledge and accept full financial responsibility for my account balance. EPIX Anesthesia will abide by all regulations of participating insurance plans.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility and that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the Center.

Patient's Name (printed): _____ **Date:** _____

Patient's Signature: _____

Center Representative: _____

Central Arizona Endoscopy
Red Mountain Professional Plaza
2158 N. Gilbert Road, Building 1 #103
Mesa, AZ 85203
(P) 480.751.3002 • (F) 480.751.3003