Suncoast Endoscopy of Sarasota
2089 Hawthorne Street, Suite 100, Sarasota, Florida 34239
Phone: (941) 952-1145 Fax: (941) 952-1175

ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits:

I hereby assign all medical and procedure benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Suncoast Endoscopy of Sarasota for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law.

I have requested medical services from Suncoast Endoscopy of Sarasota on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

The estimated facility charge for your procedure at Suncoast Endoscopy of Sarasota is $_____.

Authorization to Release Information:

I hereby authorize Suncoast Endoscopy of Sarasota to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

Disclosure of Physician Ownership Interest:

Your physician, _____, does/does not have a financial relationship with the center. You are entitled to obtain the services for which you have been referred to Suncoast Endoscopy of Sarasota at the location of your choice.

Alternative sources of the services for which you have been referred to this entity are as follows:

Sarasota Memorial Hospital
1700 S. Tamiami Trail
Sarasota, FL 34239

Doctors Hospital
5731 Bee Ridge Rd.
Sarasota, FL 34233

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

PATIENT LABEL

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EMERGENCY CONTACT INFORMATION

Relationship: _____ Phone: _____

Name: _____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Suncoast Endoscopy of Sarasota.

Do we have your permission to:

Call you at home? □ Yes □ No

If yes, may we leave the following information on your home answering machine or voicemail:

Appointment Information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No

May we call you at work? □ Yes □ No

If yes, may we leave the following information at your work answering machine or voicemail:

Appointment Information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No

PHONE NUMBER YOU CAN BEST BE REACHED _____

I give my permission to share the following information with the person(s) named below:

Name:_____ Relationship_____
Appointment □ Yes □ No Billing □ Yes □ No

Name:_____ Relationship_____
Appointment □ Yes □ No Billing □ Yes □ No

_____ _____
Patient Signature Date

_____ _____
Witness Date

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CONSENT TO MEDICAL SERVICES INCLUDING TRANSFUSION(S)

Please INITIAL EACH Line (1 thru 11)

_____ **1.** I **DO / DO NOT** ← ***(circle one – applies to #1 only)***
authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the attending physician. I understand that despite the exercise of due care the transfusion or blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types.

_____**2.** In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV or hepatitis.

_____**3.** I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.

_____**4.** I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.

_____**5.** I understand that in the rare event hospitalization is required during or immediately after procedure, my physician will arrange for my transfer to a local hospital.

_____**6**. I verify I have not eaten or taken fluids, not even water, since midnight, unless otherwise instructed by my physician.

_____**7.** Suncoast Endoscopy of Sarasota has provided me with information regarding the Patient's Bill of Rights & the Privacy Act (HIPAA) so I may be fully informed prior to treatment. (Privacy & Rights posters are posted in lobby)

_____**8.** Suncoast Endoscopy of Sarasota has informed me that they do not honor advanced directives (living wills) at the facility.

_____**9.** I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.

_____**10**. **I understand that it is my responsibility and I have arranged for a responsible adult to drive me home from Suncoast Endoscopy and remain with me following my procedure. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my procedure or as directed by my physician.**

_____**11. I understand it is my responsibility to fully disclose all my medical history.**

Date_____Time_____Patient's Signature_____

Date_____Time_____Witness to Signature_____

If patient is unable to sign complete the following:

Date_____Time_____Signature_____

Relationship_____Witness to Signature_____

PATIENT LABEL

SUNCOAST ANESTHESIA CONSULTANTS, LLC

P.O. Box 405824 Atlanta, GA 30384-5824

During your procedure, a Certified Registered Nurse Anesthetist or anesthesiologist provided by Suncoast Anesthesia Consultants, LLC, will attend you. Suncoast Endoscopy of Sarasota has contracted with Suncoast Anesthesia Consultants, LLC to provide anesthesia services to you. Suncoast Anesthesia Consultants, LLC is an independent contractor of Suncoast Endoscopy of Sarasota and Suncoast Endoscopy of Sarasota does not have any control over the work performed by Suncoast Anesthesia Consultants, LLC, or their staff. The anesthesia provider's primary purpose is to assure your safety and comfort during surgery. This will be accomplished in a variety of ways including the monitoring of your vital signs and the administration of medications that will help you relax.

Suncoast Anesthesia Consultants, LLC is a participating provider with Medicare Part B insurers. If you have coverage with this insurer, your claim will be automatically filed. With all other insurance carriers, and as a courtesy to you, we will prepare your claim form and file it on your behalf. Irrespective of your insurer, you are financially responsible for services provided. Your Anesthesia fee time is based and billed in accordance with the National Standards of the Health Care Financing Administration Rules for Anesthesia Services, Section 414.46.

ASSIGNMENT OF BENEFITS and FINANCIAL AGREEMENT

I hereby assign the benefits due to me through my insurer Suncoast Anesthesia Consultants, LLC for the service rendered. **I understand that these charges are separate from the surgeon's fee and/or facility fee**. I authorize and instruct my insurance carrier to release all records required to process my claim(s) and to make payments directly to Suncoast Anesthesia Consultants, LLC. This permission is also granted to these parties for Medicare claims filed under Title XVIII of the Social Security Act.

I understand that my insurance contract is between my insurance company and myself. I agree to forward all payments made to me by my insurer to Suncoast Anesthesia Consultants, LLC. If my insurer has not made payment within 30 days from the billing date, I will be responsible for payment plus any late fees that have accrued. I also agree that I am financially responsible for any charges and/or deductibles that my insurance company will not cover. I understand that failure to pay my account or make suitable arrangements may result in my account being turned over to collection. If this becomes necessary, I agree to pay all collection fees, court fees, attorney fees, and any other fees for collection of my account balance.

_____ _____

SIGNATURE OF PATIENT DATE

Administrative Office 941-360-1566

WHO IS DRIVING YOU HOME TODAY?

DRIVER'S NAME:_____

DRIVER'S PHONE NUMBER:_____

Suncoast Endoscopy of Sarasota is committed to providing the highest level of patient care. To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

To better serve you we have automated this process. Within 48 hours, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure Internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey online will be entered into a monthly drawing for a $100 gift certificate to Amazon.com.

Please write legibly and provide the email address to forward the survey to in the boxes below:

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

PATIENT LABEL