SACRAMENTO MIDTOWN ENDOSCOPY CENTER

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I agree whether signing as agent or as patient, that I hereby individually obligate myself to pay the Sacramento Midtown Endoscopy Center account in accordance with the Endoscopy Center's terms and rates.

I understand that I may receive separate bills from pathologists, laboratories, and the attending physician.

I hereby authorize my insurance benefits be paid directly to the Sacramento Midtown Endoscopy Center and I am financially responsible for non-covered services. I also authorize the Sacramento Midtown Endoscopy Center to release any information required to process this claim.

In the event all or any portion of an insurance claim billed by the Sacramento Midtown Endoscopy Center is rejected or remains unpaid 60 days from the date of billing, the amount involved will be considered due and payable.

Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

STATEMENT OF INTEREST: Under California law, your physician is required to inform you when they have a financial interest in the Sacramento Midtown Endoscopy Center, to which you have been referred for services. Similar services may also be obtained at other organizations. Your physician would be happy to discuss these other alternatives with you if you wish.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, Sacramento Midtown Endoscopy Center may disclose portions of this patient's record for this admission only, including but not limited to insurance carriers, fiscal intermediaries under the Social Security Act, or MediCal.

NOTICE OF PRIVACY PRACTICES: CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:
I, hereby authorize Sacramento Midtown Endoscopy Center (SMEC) to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care services.

I give my consent for SMEC to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of treatment, payment, and health care operations.

I have read and/or received a copy of the Notice of Privacy Standards, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care services.

I understand that I may revoke this consent at any time by notifying SMEC, in writing, but if I revoke my consent, such revocation will not affect any actions that SMEC took before receiving my revocation.

I understand that SMEC has reserved the right to change the facilities privacy policies and that I can obtain such changed notice upon request.

I understand that I have the right to request that SMEC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that SMEC does not have to agree to such restrictions, but that once such restrictions are agreed to, SMEC must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**

_____ _____

Printed name of patient or patient's representative **Relationship**

_____

Witness