GULF COAST ENDOSCOPY CENTER AUTHORIZATION

1. CONSENT FOR MEDICAL AND SURGICAL TREATMENT AND/OR OPERATION: The undersigned hereby consents to any anesthesia, medical or surgical treatment, or Gulf Coast Endoscopy Center services rendered to the patient under the general and special instructions of the physician. The undersigned/patient further acknowledges that no guarantee or warranty has been made by the attending physician or Gulf Coast Endoscopy Center as to the results of any treatment or operative procedure which may be performed or given.

2. RELEASE OF INFORMATION: I, the below named patient, do hereby authorize Gulf Coast Endoscopy Center and any physician treating me to release to any subsequent treating physician and any third party payor, or designee all or any part of my medical record and/or the patient named on the registration concerned with my treatment or payment of facility cost of myself and/or the patient named on this registration and to any State or Federal Governmental agencies which regulate or oversee the healthcare industry.

THIS AUTHORIZATION IS GIVEN WITH FULL KNOWLEDGE THAT SUCH DISCLOSURE MAY CONTAIN INFORMATION WHICH MAY RESULT IN DENIAL OF ALL OR PART OF SUCH INSURANCE BENEFITS OR WHICH MAY BE OTHERWISE HARMFUL OR UNFAVORABLE TO ME AND/OR THE REGISTERED PATIENT.

In addition, the undersigned and/or patient agree to hold and save the Gulf Coast Endoscopy Center, its officers, its employees and any physicians who may have examined the undersigned and/or patient harmless from any cost, loss, demand or liability resulting from such disclosure. Additionally, I authorize the release of information, if applicable, for the cancer registry program and for reporting to the Florida Cancer Data System. Additionally, I authorize Gulf Coast Endoscopy Center to obtain a summary of my medical record from the hospital for the purpose of Quality/Risk Management protocol.

3. ASSIGNMENT OF BENEFITS: I hereby assign all of my third party rights and authorize payment directly to Gulf Coast Endoscopy Center of the insurance ambulatory surgery benefits and major medical benefits due me for myself or my dependent but not to exceed the ambulatory surgery's regular charges for this period of admission for myself or any family member. In the event that all or part of such insurance benefits are denied, the undersigned and/or patient will be liable for all Gulf Coast Endoscopy Center's facilities charges.

4. **PHYSICIAN INSURANCE ASSIGNMENT:** I hereby assign all of my third party rights and authorize payment directly to any anesthetist examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for the services as described but not to exceed the reasonable and customary charge for these services.

5. RELEASE OF RESPONSIBILITY FOR VALUABLES: I hereby release Gulf Coast Endoscopy Center from all responsibility relative to the loss of or damage to money and/or valuables and/or property which are taken to the patient's room. I understand that Gulf Coast Endoscopy Center does not assume responsibility for personal possessions that are not placed for safekeeping.

q I have left all valuables at my residence as instructed during my pre-registration phone call.
q I have given my money, jewelry, credit cards, driver's license and/or anything else of value to my relative or a friend.
q I have placed my valuables in an envelope and listed the contents with a witness present. These valuables will be secured in a locked cabinet, or may be secured with patient under stretcher per patient request.

6. DISCHARGE: Should I leave before the physician in charge has discharged me, I agree to assume full responsibility for this action and to hold Gulf Coast Endoscopy Center harmless from any liability in connection therewith.

7. MEDICARE AUTHORIZATION: I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any insurance deductibles and co-insurance.

8. FINANCIAL AGREEMENT: Each person signing below, whether signing as patient, or guarantor, agrees that in consideration of the services to be rendered to the patient, which consideration is acknowledged by each of the undersigned as adequate and sufficient, he/she is hereby jointly and severally obligated to pay all charges arising from the admission of the patient. This obligation to pay all charges is unconditional and absolute. Such payment is to be rendered within sixty days of date of services.

Further, each of the undersigned hereby consents to the Gulf Coast Endoscopy Center inquiries into his/her credit history in conformity with legitimate business needs and applicable laws, rules and regulations.

Further, each of the undersigned agrees that the Gulf Coast Endoscopy Center, may, with or without notice, assign, transfer and convey to any agency or attorney its right, title and interest in and to any balance due after the patient's discharge. If suit is filed, the undersigned agrees to pay whatever additional costs, damages, fees and expenses, including attorney fees, incurred in pursuing such claim which may be determined as reasonable by the Court.

9. I authorize to discuss my medical billing information with the surgery center and agree to have messages left at my home. I acknowledge that I have received the Privacy Notice_____(Initials).