



10150 South Petunia Way Sandy, UT 84902 (801) 619-1115

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### FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: the physician performing the procedure, the Ambulatory Surgery Center (ASC), and a laboratory if specimens are obtained during your procedure.

#### FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

#### ASSIGNMENT OF/AND AUTHORIZATION TO PAY PHYSICIAN

I hereby give Granite Peaks Endoscopy consent to provide necessary healthcare services in the hope of obtaining beneficial results. I acknowledge, because of the inherent uncertainty involved in health care services, that there have been no promises of any particular outcome or result. I agree to pay for all the health care services rendered in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor. I understand that I am responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. I hereby assign to Granite Peaks Gastroenterology all medical and/or surgical benefits for which I am entitled including Medicare, private insurance, and all other health plans. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

#### ASSIGNMENT OF INSURANCE BENEFITS

Medicare/Medicare/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

#### RELEASE OF INFORMATION

I authorize the ASC to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a workers compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you.

I permit a copy/fax of this form to serve as an original signature of authorization.

#### DISCLOSURE OF OWNERSHIP

I have been advised of the following:

A physician performing the procedure may have an ownership interest in this facility and in the pathology lab.

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

**NOTE: YOU MAY RECEIVE THREE (3) SEPARATE BILLS – A BILL FROM YOUR PHYSICIAN, A BILL FROM THE FACILITY AND A BILL FOR PATHOLOGY.**

#### CERTIFICATION

**I have read and fully understand the information in this form.**

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Patient Signature

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Date

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Witness Signature

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Date