
FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: the physician performing the procedure, 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. If this account is assigned to an outside agency for collection, I/we agree to pay all attorney fees, with or without suit, court costs, and a collection agency fee up to 50%, which will be added to the outstanding balance of my account.

ASSIGNMENT OF/AND AUTHORIZATION TO PAY PHYSICIAN

I hereby give Granite Peaks Gastroenterology 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 center 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 Granite Peaks Gastroenterology 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, FACILITY, AND PATHOLOGY.

CERTIFICATION

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

Patient Signature

Date

Witness Signature

Date

RIGHT AND RESPONSIBILITIES INFORMATION SHEET

RIGHTS

1. The right to considerate and respectful care, in a safe environment, free from all forms of abuse or harassment. The patient may exercise these rights without regard to sex, cultural, economic, educational or religious background or the source of payment for care.
2. The right to full privacy concerning my medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his other healthcare.
3. The right to confidential treatment of all communications and records pertaining to his or her care and his or her visit at the facility. Except when required by law, patients are given the opportunity to approve or refuse their release. The patient also has the right to access information contained in his or her medical record within a reasonable time frame (within 48 hours of request, excluding weekends and holidays).
4. The right to be informed of my rights as a patient in advance of, or when discontinuing care. I may appoint a representative to receive this information should I so desire, and all my patient's rights apply to this person.
5. The right to know the names of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians and healthcare providers who will see him or her. The patient has the right to change the primary physician if another is available. The patient also has the right to know the credentialing process for medical staff.
6. The right to receive information from his or her physician about the illness, his or her course of treatment (including unanticipated outcomes), and prospects for recovery in terms that he or she can understand.
7. The right to receive as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
8. The right to, upon request and prior to the initiation of care or treatment, get an estimate of the facility charges, potential insurance payments and estimate of any co-payment, deductible, or other charges that will not be paid by insurance.
9. The right to participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his or her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
10. The right to be given a copy of the patient rights when admitted to the facility.
11. The right to services provided at the facility and reasonable responses to any reasonable request he/she may make for service.
12. The right to be informed that the facility is not for emergency care. Therefore all after hours' care will be directed to the closest emergency room.
13. The right to examine and receive the fees for service, the explanation of his or her bill, and the payment policy regardless of source of payment.
14. The right to refuse to participate in experimental research.
15. The right to be advised of the policy on advance directives, and living wills in the facility and to be given information upon request.
16. The right to be seen at a facility in which all physicians will carry malpractice insurance.
17. The right to redress a grievance and to be advised of the facility's grievance process should the patient wish to communicate a concern regarding the quality of the care received, or if the patient feels determined discharge date is premature.
18. The right to appropriate assessment and management of pain.
19. The right to remain free from seclusion or restrains of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
20. The right to have a family member or representative of the patient's choice notified promptly of his or her admission to the facility, and the right to have his or her personal physician notified promptly of the patient's admission to the facility.
21. The right to leave the facility, even against the advice of his or her physician, and to know which facility rules and policies apply to his/her conduct as a patient.

RESPONSIBILITIES

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses and hospitalizations, and other matters relating to his/her health.
2. The patient is responsible for reporting perceived risks in his/her care and unexpected changes in condition to his/her responsible practitioner.
3. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
4. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
5. The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
6. The patient is responsible for his or her actions should he or she refuse treatment or not follow his/her physician's orders.
7. The patient is responsible for assuring that the financial obligations of his or her care are fulfilled as promptly as possible.
8. The patient is responsible for following facility policies and procedures.
9. The patient is responsible for being considerate of the rights of other patients and facility personnel.
10. The patient is responsible for being respectful of his or her personal property and that of other persons in the facility.

ADVANCE DIRECTIVES

Federal Law directs that any time you are admitted to a health care facility, you must be told about laws concerning your right to make health care decisions. This applies to all patients, no matter what their medical condition. You have the right to consent or refuse any medical care and treatment, unless care is ordered by a court.

In an emergency, your consent to resuscitation (CPR), medical care, and treatment is assumed. In order to be in compliance with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives, we will be asking if you have a living will. If you do not, this facility's staff will offer you information on how to make a living will. Because this is an ambulatory setting, any Advanced Directive to withhold resuscitation (CPR) will not be honored while you are in this facility. Should you suffer a cardiac or respiratory arrest or other life threatening emergency, this signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, notifying you that we will **NOT** honor any previously signed advanced directives for any patient.

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

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____