MAGNOLIA ENDOSCOPY CENTER
FINANCIAL DISCLOSURE

Dear Patient:

For billing purposes, there are separate service components for which you will be billed separately.

a. Physician's Professional Charge. Your physician will bill this charge separately to you. This Billing is for the physician's professional services that are provided during your procedure.

b. Facility Charge. We will also bill a facility fee for the use of the Ambulatory Surgery Center in which your procedure is being performed. The approximate facility fee for your procedure is $_____ . If the procedure requires additional services the billing will be increased depending on the added requirement.

c. Laboratory and Pathology Charge. If you have blood drawn and/or a biopsy taken you will receive a bill from the laboratory that processes your blood work and/or biopsy.

Under certain circumstances some insurance carriers may not always cover or may deny payment for services provided. I understand the above charges, which have been discussed. Furthermore, I understand that I am responsible for my balance in full and do hereby agree to pay any balance unpaid by my insurance company.

I authorize payment to Magnolia Endoscopy Center for services rendered. I authorize release of medical benefits and release of records necessary to process this claim.

If you have any questions regarding this billing, please discuss them prior to your procedure.

The staff has informed me that the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at Magnolia Endoscopy Center.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the Magnolia Endoscopy Center where services were provided. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the center for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

SIGNED: _____

WITNESSED: _____

DATE: _____