



Andree A. Dadrat, MD FACG
Juan G. Herrera, MD
Mark S. O'Konski, MD
James W. Penuel, MD
Paul L. Yudelman, MD

**GULF COAST ENDOSCOPY CENTER
SOUTH**
7152 Coca Sable Lane
Fort Myers, FL 33908
239-985-0215
239-985-0394 (FAX)

You may receive bills from several different providers for the care rendered to you today: The physician performing the procedure; the facility; the anesthesia company; 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 and all charges related to the collection of this account should it become necessary to turn over the account to a collection agency.

Assignment of Insurance Benefits Medicare/Medigap/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the Center who 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 that the information given with regard to insurance coverage is correct.

Release of Information

I authorize the Center to release all or part of my medical records when required for the submission of any insurance claims for payment to the Health Care Financing Administration and their agents, my insurance company(s), or to my employer (if a worker's 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 this 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.

- ❖ I hereby acknowledge that the receipt of the Notice of Privacy Practices (HIPPA 100A Form) has been given to me. I understand and accept the privacy rights that it provides me.
- ❖ I hereby acknowledge that the receipt of the Patient Rights and Notification of Physician Ownership brochure and Advance Directives has been given to me **prior to the date of procedure**. I understand and accept the rights that it provides me.

Certification

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) prior to the date of the procedure performed at the center.

****THIS IS A COPY OF THE ORIGINAL FORM TO BE SIGNED THE DAY OF PROCEDURE****