Paramus Endoscopy, LLC dba
Surgical & Endoscopy Center of Bergen County
Facility Consent Form and Payment Policy

Patient name:
Date of birth:
MRN:
Date of procedure:
Procedure:
Endoscopist:

Consent for Treatment
I, the above-named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff of the above surgical center, which may include routine diagnostic procedures and such medical treatment as my doctor or his/her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at the Center.

Release of Medical Records
I authorize the Center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers' compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the Center is permitted to release such information under applicable laws.
I authorize the Center to obtain my records from the Hospital in the event of an unplanned admission.

Financial Arrangements
I authorize and direct my insurer or payor to pay directly to the above Center any or all benefits, up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me. I individually obligate myself to pay the account promptly in accordance with the regular rates and terms of the facility. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the Center for any amounts not covered by insurance. Furthermore, I understand that my insurer or payor may require certain health care services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the Center with respect to services that I choose to receive notwithstanding that my health insurer or payor has refused to give preauthorization for all or any portion of my services.

Precertification: Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services. I understand I am using my in-network/ Out of network benefits (circle one).

For in network benefits: I understand that although the surgical center is contracted with the insurance company, my insurance plan may still hold me responsible for a deductible and/or coinsurance.

For out of network benefits: This facility is not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the Center. Upon receipt of the insurance payment, I will forward the check and the explanation of benefits to the Center. In addition, I understand that my insurance plan may still hold me responsible for any deductibles and/or coinsurance.

Facility Charge: When your procedure is performed at the above surgical center, there will be a facility fee. There is a charge for the use of the surgical suite for your procedure. Fees will vary according to the type of procedure(s) that is/are being performed. Patient responsibility is dependent upon individual insurance plans.
If you have any questions regarding the above information, please speak with the Administrator.

Collection Expenses
Should my account with the surgery center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

Additional Charges

Professional Fees
These are the fees that are billed by your physician for his services in performing your procedure.
These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan.
For questions pertaining to your physician's bill, please call your physician's office.

Patient Rights
I acknowledge that I have received written and verbal information in understandable language in advance of the date of this procedure regarding Patient's Rights. <rights>

Privacy Practices
I acknowledge that I have received written and/or verbal directives regarding the Notice of Privacy practice.<privacy>

Advance Directive/Living Will/POLST
I have received information regarding Advance Directives/Living Wills/POLST in advance of the date of this procedure:
I have brought an Advance Directive or Living Will/POLST with me:
I am aware that the Center does not honor a DNR:

Ownership Disclosure
I have been notified in advance of the date of this procedure that my physician has a financial interest in this center and that I have a choice to go to another facility.

Follow-up Phone Call
We will be making a follow-up phone call to your home. May we leave a message if you are not home?

Clothing and Valuables
I fully understand that the Center is NOT responsible for any personal property (clothing, eyeglasses, dentures, etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, and keys) should be given to a family member or other responsible party for safekeeping.

Acknowledgement of Driving Risks
I am scheduled for a procedure today that will require sedation. I have been advised that I must make arrangements to be accompanied home by an individual who accepts responsibility for safely transporting me home after I leave the Surgical & Endoscopy Center of Bergen County. I understand that if I have not made arrangements to be accompanied home that day, the procedure will be cancelled. I will be personally responsible to pay the full costs associated with canceling the procedure to the Surgical & Endoscopy Center of Bergen County. I have also been advised that I should not be alone or drive until the morning after the procedure. I hereby certify that I will abide by this advice and that I release Surgical & Endoscopy Center of Bergen County, and its members, officers, agents and employees from any and all liabilities whatsoever for any injury, harm, or complications that should result if I choose to later disregard this advice.

Payment Policy

Thank you for choosing Surgical & Endoscopy Center of Bergen County. We are committed to providing you with quality health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We currently participate with most insurance companies. If you are not insured by a plan we participate with, we will verify your in-network and out-of-network benefits with your insurance carrier. You will be notified of with, we will verify your in-network and out-of-network benefits with your insurance carrier. You will be notified of the benefits quoted by your insurance carrier. Please feel free to contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments, coinsurances, and deductibles. All co-payments, coinsurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, coinsurances, and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion at the time of service.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers you will be liable for the services rendered. We also have payment plan options available.

4. Proof of insurance. All patients must sign our patient information form before your procedure. We must obtain a copy of a valid ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them; this is called coordination of benefits. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your procedure so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your insurance carrier pays you directly then you must turn the check over to: Surgical & Endoscopy Center of Bergen County within **5** business days upon receipt of payment from your insurance carrier. If your account isn't paid with 30 days of the date of statement, you will be responsible for a 2% non-payment finance charge. If your account remains past due, it will be turned over to a collection agency and you will be responsible for any non-payment fees related to this account, your anesthesia account, or any bill, as well as any collection fees, court costs, and attorney fees related to this account. Partial payments will not be accepted as payment in full unless otherwise negotiated with the billing manager. Surgical & Endoscopy Center of Bergen County is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

The undersigned certifies that this form has been fully explained, and the undersigned is satisfied that the contents are understood. The undersigned certifies that he/she has been duly authorized by the patient as the patient's legal representative or guardian to execute the above and accept on behalf of the patient.

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Signature Patient or Legal Representative

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Signature Witness