

**GALLOWAY ENDOSCOPY CENTER 7500 SW 87th Ave., Suite 101 • Miami, FL 33173**

DATE		TIME IN		LAST NAME			FIRST NAME			M.I.	DEPOSIT		ATTACHMENT	C.I.
M/F	DOB		AGE	MSW	HOME PHONE		RIDE/PHONE				NEED TO CALL	WILL BE HERE		
ADDRESS			STREET			CITY		COUNTY		STATE		ZIP		
PRIOR ADMIT		SSN		DRIVER LICENSE			OCCUPATION			WORK PHONE				
RESPONSIBLE PARTY NAME AND ADDRESS IF DIFFERENT FROM ABOVE														
RELATION TO RESPONSIBLE PARTY			RESPONSIBLE PARTY SSN			RESPONSIBLE PARTY EMPLOYER				RESPONSIBLE PARTY PHONE				
PRIMARY INS. CO. NAME/NAME OF INSURED							SECONDARY INS. CO NAME/NAME OF INSURED							
I.D. ./SSN		GROUP#		AUTHORIZATION			I.D. ./SSN		GROUP#		AUTHORIZATION			
INSURED'S EMPLOYER AND PHONE							INSURED'S EMPLOYER AND PHONE							
SURGEON				DOI		CLAIM#			ATTENTION					
DIAGNOSIS														
PROPOSED SURGERY(LINE 1)														
PROPOSED SURGERY(LINE 2)														

**FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)**

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility, specifically including GALLOWAY ENDOSCOPY Corporation and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents or employees.

**Information Privacy:** GALLOWAY ENDOSCOPY will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

I decline a copy of Privacy Practices. \_\_\_\_\_  
Initials

\_\_\_\_\_  
**SIGNATURE:**

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

\_\_\_\_\_  
**PATIENT**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**GUARANTOR**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**DATE**