2820 Mount Rushmore Rd.
Rapid City, SD 57701
Phone: (605) 721-8121

Release of Information - Assignment of Benefits - Financial Responsibility

Privacy Notice and Advance Directives. I acknowledge I received a copy of The Endoscopy Center's Privacy Notice, information regarding Advanced Directives, and Facility and Billing Policy and Information prior to receiving services at The Endoscopy Center, Inc.

☐ Information regarding Advanced Directives given to patient as requested

Release of Information. I, the undersigned, authorize The Endoscopy Center, Inc. to disclose clinical information to physicians and facilities for the purpose of continued health care and to disclose all or portions of the patient's medical record to all applicable health plans and insurance carriers ("Health Plan(s)") and may mutually exchange information with the Health Plan(s) and with Rapid City Medical Center, LLP, Peloton Anesthesia PLLC, and Clinical Laboratories of the Black Hills (referred to as "Provider(s)") who provide care related to the service provided by The Endoscopy Center, Inc. for the purposes of treatment and reimbursement. I understand the Providers listed above are not employees of The Endoscopy Center, Inc. and will send a separate bill to me or my insurance.

Assignment of Benefits. I authorize The Endoscopy Center, Inc. and Provider(s) to bill my Health Plan(s) at a rate not to exceed the respective charges of The Endoscopy Center, Inc. and/or Provider(s) and hereby direct my Health Plan(s) to make direct payment to The Endoscopy Center, Inc. or to Provider(s) as the case may be. The undersigned authorizes the use of this signature on all insurance claim submissions. A photocopy of this assignment is to be considered as valid as the original.

Guarantee of Account. I understand I am financially responsible for payment of the billed charges of The Endoscopy Center, Inc. and Provider(s) if I do not have a Health Plan(s) or if the services are not covered by my Health Plan(s). If I have a Health Plan and The Endoscopy Center, Inc. and/or Provider(s) are participating providers in my Health Plan(s) and the services are covered services under my Health Plan(s), I will be financially responsible for the charges determined by my Health Plan(s) as my responsibility, including but not limited to copays and deductibles. Patients covered by **VA, IHS, Tricare for Life will not be** obligated to pay the charges for the services provided by The Endoscopy Center, Inc. or Provider(s) if the procedure has been authorized by VA, IHS, or Tricare for Life and a prior authorization is on file.

I understand that I may call to arrange a payment plan with The Endoscopy Center, Inc. and/or Provider(s). In addition, if my account is referred by The Endoscopy Center, Inc. or by Provider(s) to an attorney or licensed collection agency, I understand I will be responsible for attorney and collection agency fees.

I, the undersigned, agree, whether as agent or as patient, in consideration of the services rendered to the patient, I agree to pay to the account of The Endoscopy Center, Inc. and the Providers in accordance with their respective rates and policies in accordance with the terms set forth above.

I have read and fully understand this agreement.

_____ _____

Patient Date

_____ _____

Responsible Party Date

(Person responsible for bill on patient's behalf if applicable)

The Endoscopy Center, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): The Endoscopy Center, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Deutsch (German): The Endoscopy Center, Inc. erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab