ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

Insurance Network Disclosure Form

I, _____ have been informed that this facility,
Print Patient's Name

Advanced Endoscopy & Surgical Center, is:

- ***In-Network*** with my insurance plan
- ***Out-of-Network*** with my insurance plan and further, if I am out-of-network, the following applies:

  ( ) My potential financial responsibility may exceed my co-payment, deductible or co-insurance with my health insurance plan;

  ( ) I may be responsible for any excess amount above the allowed amount the health insurance pays or reimburses the provider for healthcare services I received; and

I was informed to contact my health insurance provider, prior to the day of my procedure, to identify the potential costs which I am/may be responsible for according to my plan/coverage.

I acknowledge that I am knowingly and voluntarily accepting financial responsibility associated with the healthcare services I receive.

_____ _____

Patient/Legal Guardian Name Printed ***Witness Name Printed***

_____ _____

Patient/Legal Guardian Signature ***Witness Signature***

_____

Date

(Revised: 08/29/2018)