

CONDITIONS OF ADMISSION

Consent for Medical Diagnostic Studies, Evaluation and/or Treatment:

I voluntarily consent to the procedures which may be performed during this visit to Austin Endoscopy Center (AEC), including but not limited to diagnostic, medical and/or surgical treatment under the general and special instructions of my physician. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made about the result of treatments or examinations in AEC. I understand that for Continuous Quality Improvement purposes, some non-personal data relating to my care may be placed into AEC's computer system and may be shared with a national database.

Consent for Testing for Purposes of Accidental Exposure:

I understand state law allows that in the event a health care worker is exposed to my blood or body fluids during my admission, my blood shall be tested at no cost to me, using a special coded system to ensure confidentiality, for the HIV antibody and other communicable diseases. If such exposure occurs, I will receive additional information about such tests. The results of these tests will not prejudice my patient relationship with the Austin Endoscopy Center.

Release of Responsibility for Valuables:

I understand and agree that AEC shall not be liable, and there is no reimbursement available for the loss of or damage to any of my personal property, such as money, jewelry, documents, glasses, dentures or hearing aids. I have been advised to give all valuables and unnecessary articles of clothing to the person accompanying me for safekeeping while I am at AEC.

Policy Regarding Payment:

I understand that the physicians providing my treatment at AEC are not employees or agents of the Austin Endoscopy Center. Therefore, in addition to Austin Endoscopy Center charges, I will receive separate bills for the following physician services: Anesthesiologist(s), Attending Physician/Surgeon and/or Consulting Physician(s), Radiologist(s) and/or Pathologist(s). I, the undersigned patient (or responsible party if different from patient) hereby assign and transfer to the Austin Endoscopy Center and the physicians involved in my care, any and all right, title and interest in any insurance payments for services provided. It is understood that insurance requirements, such as pre-certification, pre-authorization, or second opinions shall remain my sole responsibility and/or that of my family or legal representative. Regardless of any and all assignments, I agree that I am financially responsible for any charges not covered by insurance benefits, including but not limited to deductibles and coinsurance which are due upon admission. I understand that if Medicare or other insurance companies deny payment, I will be responsible for payment.

Release of Information:

Austin Endoscopy Center is hereby authorized to furnish medical information, as necessary, for the payment of my charges by my insurance carrier, Medicare, Medicaid, or any other payer or agency, from the medical records compiled during my admission. I also authorize release of copies of my medical records to health care practitioners and organizations who are involved in my continued care after discharge. Austin Endoscopy Center recognizes that information regarding my health care is confidential. Unless I request otherwise, Austin Endoscopy Center will only release my health care information as specified by law. I understand that I have the right to obtain copies of my health care information for a fee.

Certification:

I have been instructed and I agree not to operate a motor vehicle, enter into any legal contracts, drink any alcoholic beverage or take any drugs (unless prescribed by a physician) for twenty four (24) hours following my procedure because I have been given narcotics and/or pain medicine.
_____ will drive me home from AEC following my procedure and will not allow me to drive because of the narcotics/pain medicine I have been given. I have read this form, or it has been read to me, and I understand and agree to the above terms and conditions. I certify that the information given to the Austin Endoscopy Center for this admission is correct, to the best of my knowledge.

Patient/Authorized Representative Signature

Relationship to Patient

Responsible Adult Driver (Print & Signature)

Date/Time

Witness

Date/Time