METRO ATLANTA ENDOSCOPY, LLC

PATIENT NAME: ______________________________

OWNERSHIP

I understand that Dr.'s Horney, McGahan, Carson, Shapiro and Weinstein are in fact the owners of the Metro Atlanta Endoscopy, LLC. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Metro Atlanta Endoscopy, LLC.

RELEASE OF INFORMATION

Metro Atlanta Endoscopy, LLC is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physician of Metro Atlanta Endoscopy, LLC. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Metro Atlanta Endoscopy, LLC to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Metro Atlanta Endoscopy, LLC all surgical, medical insurance and/or other benefits, if any, and otherwise payable to me for the services. I agree to endorse the check(s) over to Metro Atlanta Endoscopy, LLC. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Metro Atlanta Endoscopy, LLC from the obligor of said benefits. I understand that payment is due when services are rendered. I assign all medical and/or surgical benefits including major medical benefits for services provided to Metro Atlanta Endoscopy, LLC. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Metro Atlanta Endoscopy, LLC be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

PRESCRIPTION POLICY

Prescriptions for medications may be issued based on the results of your procedure. No medications will be refilled. Please contact your physician's office to request a refill if needed. If you have an emergency situation, you will be directed to the emergency department at the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

PATIENT BILL OF RIGHTS NOTICE

I have received and understand the Patient Bill of Rights.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the Administrator of Metro Atlanta Endoscopy, LLC.The Administrator may be reached at 404-255-4333. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights. Patient will be kept up-to-date on the grievance status.

ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life threatening emergency. Metro Atlanta Endoscopy, LLC is not equipped to determine if there is a life threatening event; patient will be treated and stabilized, and transported to the hospital of choice by ambulance. I consent to emergency transfer to the hospital in case of the need for emergency hospital care. A copy of the advance directive may be placed on the chart if the patient desires and forwarded to the hospital in the event of a transfer. Information regarding advance directives is made available upon the patient's request. The admitting facility is not affiliated or in partnership with Metro Atlanta Endoscopy, LLC.

______________________________	____________________	__________AM/PM
Patient Signature or Responsible Party	Date	Time

____
Relationship if not the patient