## General Consent

1.Consent: I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include diagnostic, radiology and laboratory procedures, anesthesia, therapeutic procedures, drugs, and medical, nursing and facility care. I understand I will sign a separate informed consent for my surgery/surgical procedure and for anesthesia.

2.Release of Information: I authorize Kanis Endoscopy Center. to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substances abuse, psychiatric/psychological services records, and social work records, if any to the extent that the release of such records is permitted under federal and state law. See Notices of Privacy Practices for further information.

3.Valuables: I release Kanis Endoscopy Center. from responsibility for all personal articles which I have with me during the time I am a patient at the Facility. I understand that the Facility is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession while a patient in the surgery center.

4.Payment: I assign and authorize payment from my insurance company directly to Kanis Endoscopy Center, for any and all services rendered. I agree to pay, at the time of discharge or on an interim basis (agreed upon by the Facility), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay the Facility all charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies.

5.Relationship Between Facility and Physicians. I acknowledge that medical/surgical services at Kanis Endoscopy Center are provided by its employees as well as physicians on its Medical Staff and other health care providers, many of whom are not employees of Kanis Endoscopy Center but are licensed independent practitioners who have been granted the privilege of using the Center's facilities for the needs of their patients. I understand that my attending physicians (or his/her designee) will be responsible for my care at all times.

6.Medicare/Medicaid Payment. I certify that the information given by me in applying for, or assigning, payment under Medicare or Medicaid is correct. I request payment of authorized Medicare Medicaid benefits be paid to Kanis Endoscopy Center on my behalf for services furnished to me. I authorize Kanis Endoscopy Center to release any information about me that is necessary to act on this request for payment.

7.I acknowledge that I have received the following information both verbally and in writing prior to my procedure: Patient Rights and Responsibilities, Disclosure of Physician Ownership as applicable, the surgery center's policy on Advanced Directives, and Advanced Directive information and forms if requested.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

I received a copy of the Privacy Practices yes, no, n/a

I have been provided a statement of “Patient Rights” at least 24 hours in advance of this procedure yes, no, n/a

I received “Patient Rights” statement the same day that I saw my MD and the procedure was scheduled yes, no, n/a