The Endoscopy Center of New York
ASSIGNMENT OF BENEFITS

AUTHORIZATIONS & DISCLOSURES

These **AUTHORIZATIONS and ASSIGNMENT OF BENEFITS** MUST BE SIGNED BY THE PATIENT (or by the party legally responsible for a minor or physically or mentally incapacitated patient), and by the party financially responsible for the patient, if other than the patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

1. **AUTHORIZATION FOR MEDICAL TREATMENT:** Each of the undersigned hereby authorize any anesthesia, medical or surgical treatment, and Center service rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated for purposes of diagnosis, treatment and medical care. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OF SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.
2. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** For the purpose of reimbursement: the Center and each treating practitioner, including, if applicable, PATHOLOGY, ANESTHESIA, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my insurance companies, and other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I the undersigned do hereby permit **The Endoscopy Center of New York** to give information/medical records from my file, or from the person I appoint, to the insurance company or its agents, in order to process a claim for payment. Only information that is reasonable or necessary to process the claim can be released.
3. **RELEASE OF RESPONSIBILITY FOR PERSONAL PROPERTY/VALUABLES:** It is understood that the Center is not responsible for personal property or valuables retained by the patient, including dentures, eyeglasses, prosthesis or items of sentimental value, but will exercise due care in the protection of same during a patient's procedural visit.
4. **NOTICE OF PRIVACY PRACTICES** HIPAA COMPLIANCE: I have received a copy of the Center's Notice of Privacy Practices (NPP) and I understand that Endoscopy Center of NY is affiliated with the Mount Sinai Health System (Mount Sinai Doctors Faculty Practice, the Icahn School of Medicine at Mount Sinai, Mount Sinai Beth Israel, Mount Sinai Beth Israel Brooklyn, The Mount Sinai Hospital, Mount Sinai Queens, Mount Sinai West, Mount Sinai St. Luke's, New York Eye and Ear Infirmary of Mount Sinai) and that my health records will be shared with the Mount Sinai Health Information Exchange.
5. **ADVANCE DIRECTIVE:** I have received the notice of Advanced Directive
6. **PHYSICIAN OWNERSHIP DISCLOSURE: The Endoscopy Center of New York** provides services only to patients admitted by private practitioners who are members of the medical staff, some of whom retain joint ownership of the surgery center.
7. **ADDITIONAL PROVIDERS**: I have been advised that specimens obtained during my procedure may need to be sent to another healthcare provider for analysis (such as a laboratory, a pathologist, etc.); that those other healthcare providers may not participate with any Health Plan I may be enrolled in; that I will be responsible for any additional costs due for out-of-network services; and that further information concerning those providers is available upon request.

8. **MEDICARE/CERTIFICATION AND AUTHORIZATION:** (IF APPLICABLE). The information that I gave when I applied for payment under Title XVIII of the Social Security Act is correct as far as I know. I permit any holder of medical or other information about me to release it to the Social Security Administration (or its intermediaries or carriers) if it is needed for this or a related claim. I want the Center and all of my doctors to be paid directly for any benefits that may be payable to me. I permit these doctors and the Center to file a claim to Medicare for payment.

9. **PERMISSION TO PAY INSURANCE BENEFITS: MEDICAID** (IF APPLICABLE). I state that I received the services for this claim and want payment for these services to be paid for me. I want the Center and all of my doctors to be paid directly for any benefits that may be payable to me. I permit these doctors and the Center to file a claim to Medicaid for payment. The information I gave when I applied for payment under Title XIX of Medicaid is correct as far as I know. I permit any holder of medical or other information about me to release it to the Division of Medical Assistance and Health Services (or its intermediaries or carriers) if it is needed for this or a related claim.

10. **ASSIGNMENT OF INSURANCE AND THIRD PARTY BENEFITS:** The undersigned, hereby assign, transfer, and set over unto **The Endoscopy Center of New York** all benefits payable to them or either of them now due and to become due and payable, including major medical benefits, by reason of this admission under any policy of insurance or other health care coverage in which the patient is a covered beneficiary.

11. **CONSENT TO APPEAL INSURANCE COMPANY DENIAL OF BENEFITS:** If I am enrolled with a Health Plan, I hereby designate the Center as my authorized representative in connection with any claim, right, or cause in action under that Health Plan, with the right and ability to pursue such claim, right, or cause of action under that Health Plan (including but not limited to, an ERISA benefit plan as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred for the services I receive from the Center.

12. **THE ESTIMATED RATE AMOUNT FOR OUT-OF-NETWORK SERVICES IS AVAILABLE UPON YOUR REQUEST. YOU MAY BE RESPONSIBLE FOR CO-INSURANCE AND DEDUCTIBLES NOT COVERED BY YOUR INSURER. PLEASE NOTE THAT SUCH ESTIMATES CANNOT ACCOUNT FOR UNFORESEEN MEDICAL CIRCUMSTANCES THAT MAY ARISE WHILE THE SERVICES ARE PERFORMED.**

THE UNDERSIGNED, CERTIFIES THAT THEY HAVE READ AND UNDERSTAND
EACH OF THE ABOVE AUTHORIZATIONS

DO NOT sign these authorizations without a full understanding of each.

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Signature of Patient/legal guardian or sponsor (relationship)   Date and time

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Print name of patient/legal guardian or sponsor

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Witness to signature