DIGESTIVE HEALTHCARE CENTER

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NADER YOUSSEF, M.D., FAAP, FACG

Dear Patient,

In preparation for your procedure which has been **scheduled** at Central Jersey Ambulatory Surgical Center, LLC, we ask that you review this packet as soon as possible.

This packet includes:

1. Procedure preparation instructions
2. Anesthesia instructions
3. Informed consent for Gastrointestinal endoscopy
4. Facility disclosure of advance directives
5. Patient rights and responsibilities
6. Disclosure of ownership
7. Payment authorization

This will allow you the time to prepare and understand the paper work you will be asked to read and **sign the day of your procedure**. This will help us to achieve our goal of keeping our patients well informed.

Please call with any questions you may have. We look forward to seeing you on the day of the procedure.

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Mark L. Greaves, M.D.
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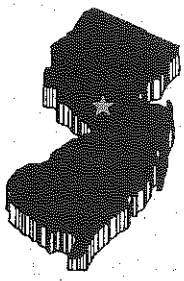
8/4/2011

511 Courtyard Drive, Hillsborough, NJ 08844
Phone: (908) 218-9222 Fax: (908) 218-9818
WWW.DHCCENTER.COM



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CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey 08844
Bldg. 500 - 1st Floor • Phone: 908-895-0001 • Fax: 908-685-8833

Accredited by the

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Dear Patient,

Your Physician has scheduled you for a procedure in the Central Jersey Ambulatory Surgical Center. We are proud to inform you that we are accredited by Accreditation Association for Ambulatory Health Care, Inc.

It is very important that you read in full, the entire packet of information given to you. You can expect to be in the Center for approximately an hour and a half. If your driver is not going to wait for you in the Center, please have them come back to pick you up in an hour and a half. If you prefer, we can give them a call at the conclusion of your procedure. **The center closes at 5:00 pm, all patient rides must arrive by 5:00 pm.**

Please call our Center if you have any questions or go in to [www.cjasc.com]. You may also ask for me, or if I am not available one of our Nurses will gladly assist you. I do ask that you please **do not** leave messages on the voice mail. Sometimes these messages are left on phones that are not regularly attended and we do not want to miss your call.

The staff and I at the Center look forward to assisting you before, during and after your scheduled visit.

Sincerely,

Sheenagh Hirsch, RN,CGRN
Director of Nursing

Revised 8/16/2011

The day of the procedure please bring a photo ID and your insurance card.

ANESTHESIA INSTRUCTIONS

You will be receiving sedation for the procedure your doctor has scheduled. It is very important that you read and follow these instructions.

BEFORE THE PROCEDURE:

1. PLEASE FOLLOW DIETARY INSTRUCTIONS ON THE COLONOSCOPY OR UPPER ENDOSCOPY INSTRUCTION SHEET THAT WAS GIVEN TO YOU. YOU MAY HAVE CLEAR LIQUIDS UP TO **FOUR** HOURS BEFORE YOUR PROCEDURE (WATER, CLEAR JUICES SUCH AS APPLE OR WHITE GRAPE, BROTH, CLEAR TEA, BLACK COFFEE. **NO** MILK OR ORANGE JUICE).
2. If you take PILLS in the morning, please **take** with a small sip of plain water. This is especially important if you have:
   Heart or blood pressure problems – and continue to wear your nitroglycerine patch if it has been prescribed by your doctor.
   Asthma – also use your inhaler as directed and bring it with you to the office.
3. **If you are diabetic** – to avoid low blood sugar, do **not** take your pills or insulin in the morning of the procedure. You can continue it after you have had something to eat. Also check your blood sugar frequently during your preparation diet and especially the morning of the procedure. If you are taking insulin, it is always a good idea to check with your primary doctor/endocrinologist as to the best way to manage your blood sugar. Bring your insulin with you.

   If you are unsure about taking any medications, please call the OFFICE.
4. **IF YOU ARE TAKING COUMADIN/PLAVIX/ASPIRIN IT MAY NEED TO BE STOPPED** before your procedure. Please ask your doctor. (These medications are **usually stopped 5-7 days before procedure)**
5. **IF YOU HAVE A DEFIBRILLATOR – Your procedure will be scheduled at Somerset Medical Center.**
6. Wear comfortable, loose clothing such as a sweat suit and T-Shirt. No metal.
7. If you are a smoker, no cigarette for six hours before your procedure is advised.
8. If you are child bearing age, a 15-50 year old female, we will be doing a urine test on you. Please do not empty your bladder when you arrive.

AFTER THE PROCEDURE:

1. You must arrange for a responsible adult (18 & over) to drive you home. Going home alone in a taxi is not allowed. Someone needs to care for you. Please ask our office for assistance if necessary.
2. The effects of anesthesia can persist for 24 hours. After receiving the sedation, you must exercise extreme caution before engaging in any activity that could be harmful to yourself or others (such as driving a car), do not make any important decisions, and do not drink alcoholic beverages during this time period.
3. Take only medication that is prescribed by your doctor for your care.
4. After your procedure, you may have anything you like to eat or drink. You will probably want to start with something light, and plenty of fluids. Avoid items that cause GAS. E.g. Sodas, Salads.
5. If your procedure required a METAL clip. NO MRI for 30 days

PATIENT RIGHTS AND RESPONSIBILITIES
CENTRAL JERSEY AMBULATORY SURGICAL CENTER

I. The patient shall be informed verbally and in writing of his/her rights in advance of the date of the procedure, in terms that the patient can understand. A signature acknowledging receipt of verbal and written notification of these rights in advance of the day of the procedure will be obtained by the patient and or legal guardian and placed in the patient's chart as part of the permanent medical record.

II. The patient will be informed of the services offered at the Surgery Center, the names of the professional staff and their professional status of who is providing and/or responsible for their care, including information on the facilities provisions for emergency and after hours and emergency care.

III. The patient will be informed of the fees and related charges, including the payment, fee, deposit, and refund policy of the Surgery Center and any charges not covered by third-party payers or by the Surgery Center's basic rate.

IV. The patient will be informed of other health care and educational institutions participating in the patient's treatment.

V. The patient will be informed of the identity and the function of these institutions, and he/she has the right to refuse the use of such institutions.

VI. The patient will be informed, in terms that the patient can understand, of his/her complete medical/health condition or diagnosis, the recommended treatment, treatment options, including the option of no treatment, risks of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, then the information will be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly will be documented in the patient's chart.

VII. The patient will participate in the planning of his/her care, and has the right to refuse such care and medication. Upon refusal it will be documented in the patient's chart.

VIII. The patient will be included in experimental care if the patient has agreed to such and gives written and informed consent to such treatment, or when a guardian has consented to such treatment. The patient also has the right to refuse such experimental treatment.

IX. The patient has the right to voice grievances or recommend changes in policies and services to the Surgery Center personnel, the governing authority and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination, or reprisal.

X. The patient will be free from mental and physical abuse, free from exploitation, free from harassment, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of the Surgery Center's personnel.

XI. The patient will be assured of confidential treatment of information about him/herself. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another healthcare facility to which the patient was transferred requires that information, or unless the release of the information is required or permitted by law, a third party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

XII. The patient will receive courteous treatment, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.

XIII. The patient will not be required to work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules.

XIV. The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.

XV. The patient has the right to expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care.

XVI. The patient has the right to information regarding credentialing of Health Care Professionals at the Center.

XVII. The patient shall be informed verbally and by written notice in advance of the date of the procedure, of his/her physicians financial interest or ownership in the ASC; The signed copy of patient acknowledgement and notification of the physician financial interest or ownership will be placed in the patient's chart as part of the permanent medical record.

XVIII. The patient shall be informed verbally and by written notice in advance of the date of the procedure, information on the ASC's policy on advance directives, including a description of applicable NJ health and safety laws and, if requested, official NJ advance directive forms. The signed copy of patient acknowledgement and notification of the ASC policy on advance directives will be placed in the patient's chart as part of the permanent medical record.

XIX. The patient has the right to refuse any treatment, except as otherwise provided by law.
XX. The patient will not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
XXI. The patient has the right to change their provider if other qualified providers are available.
XXII. The patient has the right to be informed about procedures for expressing suggestions, including complaints and grievances, including those regulated by state and federal regulations.
XXIII. The patient has the right not to be misled by marketing or advertising regarding the competence and capabilities of the organization.
XXIV. The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
XXV. The patient has the right to receive care in a safe setting free from all forms of abuse and harassment.
XXVI. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
XXVII. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
XXVIII. A patient is responsible for following the treatment plan recommended by the health care provider.
XXIX. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
XXX. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
XXXI. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
XXXII. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
XXXIII. A patient is responsible to provide complete and accurate information about his/her health, any medications, including herbals and over the counter supplements and any allergies or sensitivities
XXXIV. A patient is responsible to follow the treatment plan prescribed by his/her provider.
XXXV. A patient is responsible to provide a responsible adult to transport hi/her home from the facility and remain with him/her for 24 hours if required by his/her provider.
XXXVI. A patient is responsible to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care
XXXVII. A patient is responsible to be respectful of all the health care providers and staff, as well as other patients.
XXXVIII. The administrator will provide upon request to all patients and/or their families, the names, addresses, and telephone numbers of the following offices where complaints may be lodged:

Division of Health Facilities
Evaluation and Licensing
New Jersey Department of Health
PO Box 367
Trenton, NJ 08625-0367
800-792-9770

State of New Jersey
Office of the Ombudsman for the
Institutionalized Elderly
PO Box 808
Trenton, NJ 08625-808
609 943-4023
877-582-6995 toll free

The administrator shall also provide all patients and/or their families, upon request, the names, addresses and telephone numbers of offices where information concerning Medicare and Medicaid coverage may be obtained

The website for the Medicare Ombudsman is: http://www.cms.hhs.gov/center/ombudsman.asp is available to the public and ASC patients to get information about the Medicare and Medicaid programs, prescription drug coverage, and how to coordinate Medicare benefits with other health insurance programs. The website also includes information about filing a grievance or complaint.

Addresses and telephone numbers contained in line 38 will be conspicuously posted throughout the facility, including, but not limited to, the admissions waiting room, the patient service area of the business office, and other public areas.

TO HEAR THE PATIENT RIGHTS AND RESPONSIBILITIES VERBALLY:
DIAL 908 895 0001 extension 350

Central Jersey Ambulatory Surgery Center

511 Courtyard Dr. Building 500
Hillsborough, NJ 08844

Advance Directive and Patient rights Interview

1. Does the patient have an Advance Directive (Living Will, Durable Power of Attorney, Proxy)?
   YES ( ) NO ( )

2. If answer to number one is "Yes", did patient provide a copy on admission?
   YES ( ) NO ( )

3. Written information regarding Advance Directives was requested by patient and given to patient.
   YES ( ) NO ( )

4. I have been given a copy of the PATIENTS BILL OF RIGHTS.

5. The facility will not be held responsible for any valuables. (PLEASE DO NOT WEAR JEWELRY/METAL,including bras & zippers this is required should you need cautery during your procedure)

6. I am aware that I will:
   a) be given a copy of discharge instructions, including anesthesia to review at home. I acknowledge that I may need to phone the physician if I have any questions.
   b) I need a responsible adult with me at time of discharge.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

CENTRAL JERSEY AMBULATORY SURGICAL CENTER
511 Courtyard Dr., Hillsborough, NJ 08844
Tel: (908) 895-0001 Fax: (908) 685-8833

Patient Label

INFORMED ENDOSCOPY CONSENT

I hereby authorize Dr. _____,("physician")and such assistants as may be selected to treat my condition(s) procedure to be (check where applicable)

A. The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr._____ , and I understand the nature of the procedure to be (check where applicable):

- ☐ Flexible Sigmoidoscopy (insertion of tube into rectum/colon) with possible biopsy (tissue sample)
- ☐ Colonoscopy (insertion of tube into rectum/colon) with possible biopsy, polypectomy (polyp removal), injection therapy, or control of bleeding
- ☐ Infrared Coagulation of Hemorrhoids (IRC) (insertion of probe into rectum to coagulate hemorrhoids)
- ☐ Esophagoscopy Gastroscopy Duodenoscopy (EGD) with possible biopsy (tissue sample) /cautery / dilation (stretching of a narrowing) / (Insertion of tube into throat, stomach and duodenum)
- ☐ Other: _____

B. It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

- Contrast Radiographic Studies (Barium Enema or GI Series) – X-Rays
- Observation (not to do the procedure)

C. I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

- **Bleeding (increased risk if biopsy or polypectomy is performed) may require a blood transfusion.**
- **Perforation (a hole torn inside possibly requiring a procedure or surgery to be performed: the presence of extensive diverticulosis are more prone to complications)**
- **Infection (possibly requiring intervention, such as antibiotic treatment, surgery or other treatments)**
- **Aspiration (fluid entering the lungs)**
- **Post Polypectomy Burn Syndrome**

D. I have also been told that if the procedure is not performed, what may happen to me is: **The condition(s) may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding / tumor or growth / disease).**

E. It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the operation or other procedure commenced.

F. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest – etc., that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and procedure is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. **Even the best experienced physicians can miss abnormal growths possibly related to poor prep, spasm, diverticular disease, etc.**

G. I consent to the retention or disposal of any tissue or parts, which may be removed.

H. I also authorize the presence of observers, as considered appropriate or advisable by the surgeon or his/her associate or assistant according to the center policy and in accordance with HIPAA and the state law.

I. If my physician or a member of the center staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood, including but not limited to the human immunodeficiency virus (HIV) and hepatitis.

_____ _____

Witness to Signature — Signature of Patient or other person responsible

_____ _____

Witness to Signature — Relationship when patient is unable to sign or is a minor

PHYSICIAN'S CERTIFICATION

I, Dr. _____ , certify that I have explained the specified operation(s) or procedure(s), the attendant risk and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

_____ _____

Physician's Signature — Date

Revised 11/11/10

DISCLOSURE

Public law/rule of the Federal Government and the State of New Jersey/Board of Medical examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Please take notice that the following practitioners have a financial interest in referring to

Central Jersey Ambulatory Surgical Center
511 Courtyard Drive,
Hillsborough
New Jersey
08844

You may, of course, seek treatment at a health care facility of your own choice. A listing of alternative health care facilities can be found in the classified section of your telephone directory under the appropriate heading.

PHYSICIAN OWNERS AND GOVERNING BODY

Dr. Charles Accurso
Dr. Claudia Barghash
Dr. Gary Ciambotti
Dr. Alan Gingold
Dr. Cory Vergilio
Dr. Mark Greaves

CENTRAL JERSEY AMBULATORY SURGICAL CENTER
ADVANCE DIRECTIVES DISCLOSURE

There are several different types of Advance Directives, including Living will, Health Care Proxy, Do Not Resuscitate

A. Due to the elective nature of the procedures performed in this facility, Do Not Resuscitate orders are not honored in the facility. Patients wishing to maintain their status of Do Not Resuscitate will be given the option of scheduling their procedure in the hospital.

B. No patient will be discriminated against based on whether or not that individual has executed an advance directive.

C. Written information shall be provided to all adult patients at the time of admission concerning:

    1. An individual's rights under State law to make health care decisions, including the rights to accept or refuse medical or surgical treatment and the right to formulate advance directives;

    2. The Center's policy respecting these rights.

D. Written follow-up information will be provided to all interested adult patients, their families and health care representatives upon admission. Said information shall include information and materials about advance directives and a description of the process by which a patient may obtain assistance in the execution of an advance directive.

E. Physicians shall be encouraged to discuss advance directives with their patients prior to admission.

F. Patient and staff education regarding patient rights and advance directives will be provided by The Center.

G. A competent adult may execute an advance directive at any time. Once executed, the declarant may revoke an advance directive by the following means:

    1. Notification, orally or in writing, to the patient's health care representative (if any), physician, nurse or other health care professional, or other reliable witness, or by any other act evidencing an intent to revoke the document.

    2. Execution of a subsequent advance directive.

        i. An incompetent patient may suspend an advance directive by notification, orally or in writing, to the patient's health care representative (if any), physician, nurse or other health care professional, or other reliable witness, or by any other act evidencing intent to revoke the document.

H. Valid advance directives will become a permanent part of a patient's medical record when made available.

I. For more information and to download New Jersey's Advance Directive forms please visit: http://nj.gov/health/healthfacilities/documents/ltc/advance_directives.pdf

Central Jersey Ambulatory Surgery Center
Advance Directive/Living Will Declaration

Instructions: Consult this column for guidance.	To my family, Doctors, and all those concerned with my care
This declaration sets forth your decisions regarding medical treatment.	I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.
You have the right to refuse the treatment you do not want, and you may request the care you do want.	These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in doing so to be free of any legal liability for having followed my directions.
You may list specific treatment you do not want: e.g., CPR, cardiac resuscitation-Mechanical respiration-Feeding Tubes-Intravenous Fluids. Your general statement above will suffice.	I especially do not want
You may want to add other instructions directing the care you do not want: e.g. pain management-to die at home.	Other instructions/comments
If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.	PROXY DESIGN CLAUSE: In order to carry out my instructions as stated above and to interpret them, I designate the following person to act on my behalf Name:_____ Address:_____ Home Phone #:_____ Work Phone #:_____
	If the person named above is unable to act on my behalf, I authorize the following person to do so: Name:_____ Address:_____ Home Phone #:_____ Work Phone #:_____

Patient's Signature:_____ Witness:_____
Date:_____ Date:_____

C. J. A. S. C.

CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey 08844
Bldg. 500 - 1st Floor • Phone: 908-895-0001 • Fax: 908-685-8833

Patient Name: _____DOB:_____

Performing Physician: _____

CONSENT FOR ANESTHESIA

I consent to the administration of Anesthesia or Sedation, and to the use of such Anesthetics or Sedatives as my physician may deem appropriate. I certify that I have read and fully understand this consent statement which has been preceded by an explanation of the risks, benefits, alternatives, and possible complications by my physician, that the explanations therein referred were made to me by Physician (Name) _____ and are understood by me, and that all blanks or statements requiring insertion or completion were filled in before I signed.

Anesthesia Plan: **MAC > CONSCIOUS SEDATION > GENERAL ANESTHESIA**

NO SEDATION

I hereby certify that the risks and benefits of the proposed procedure/treatment as well as the alternatives, have been explained to me by the patient or to the authorized person/ responsible other.

_____ _____
Signature: PATIENT/AUTHORIZED PERSON DATE

_____ _____
Signature: WITNESS DATE

_____ _____
Signature: ANESTHESIOLOGIST DATE

MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME:_____ DOB:_____
PHARMACY NAME:_____ LOCATION:_____ PHONE#_____
ALLERGIES: (SEE BELOW) MEDICATION: Y N FOOD (INCLUDING EGGS OR SOY) Y N LATEX Y N

MEDICATION/REACTION	MEDICATION/REACTION

(List all medications, OTC drugs, Herbal supplements) **Write NONE if no meds are taken**

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○ BLOOD THINNERS (DENIES)		○	
○		○	
○		○	

ATTESTATION: The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Patient/Guardian Signature:_____ Date:_____

Nursing Use Only: Source: ___Patient ___Family ___List
Obtained By: Pre-OP RN Signature:_____ Date:_____
Anesthesiologist_____ Date:_____
OR RN Signature:_____ Date:_____

You may safely resume taking all of the above medications after your procedure, including over the counter medications and dietary supplements prescribed by your physician. EXCEPTIONS SEE BELOW:

Medication Dosage/Frequency	Resume Medication Date/Time

New Medication Prescribed Following Your Procedure

Medication	Dosage/Route/Frequency	Next dose

PACU RN Signature:_____ Physician Signature:_____

Revised 7/26/11

C.
J.
A.
S.
C.

CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey, 08844
Bldg.500 - 1st Floor · Phone: 908-895-0001 · Fax: 908-685-8833

PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE TO PAY DIRECTLY CENTRAL JERSEY AMBULATORY SURGICAL CENTER. ANY BENEFITS FOR THE AMBULATORY SERVICE(S) RENDERED TO ME OR MY DEPENDENT UNDER MY INSURANCE PLAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ IN NETWORK

I AM SCHEDULED FOR A PROCEDURE AT CENTRAL JERSEY AMBULATORY SURGICAL CENTER. THEY ARE IN NETWORK WITH YOUR INSURANCE. YOU ARE RESPONSIBLE, IF YOU HAVE ANY IN NETWORK **FACILITY DEDUCTIBLE, CO-INSURANCE** AND **COPAY**. THEREFORE YOU WILL RECEIVE A BILL. IF YOU DO NOT KNOW YOUR **FACILITY** BENEFITS, PLEASE CALL YOUR INSURANCE COMPANY PHONE NUMBER ON THE BACK OF YOUR CARD, SO YOU WON'T BE SURPRISED IF YOU RECEIVE A BILL.

_____ OUT OF NETWORK

I AM SCHEDULING FOR A PROCEDURE AT THE CENTRAL JERSEY AMBULATORY SURGICAL CENTER. SINCE THE FACILITY IS NOT CONTRACTED WITH MY INSURANCE COMPANY, THE REIMBURSEMENT MAY BE SENT TO ME INSTEAD OF THE CENTER. UPON RECEIPT OF THE INSURANCE PAYMENT, I WILL **FORWARD THE CHECK AND THE EXPLANATION OF BENEFITS TO THE CENTER.** MY INSURANCE PLAN MAY STILL HOLD ME RESPONSIBLE FOR A DEDUCTIBLE AND/OR CO-INSURANCE

_____ _____
PRINT NAME OF PATIENT BIRTHDATE

_____ _____
SIGNATURE OF INSURED/AUTHORIZIED PERSON DATE

_____ _____
WITNESS DATE