AUTHORIZATION

I hereby authorize Carbon-Schuylkill Endoscopy Center (CSEC) to apply for benefits on my behalf for covered services rendered by CSEC. I request that payment from my insurance company be made directly to Carbon-Schuylkill Endoscopy Center or to the party that accepts assignment. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient or Personal Representative Signature Date

I certify that the information I have reported with regards to my insurance coverage is correct. I understand and agree to pay all bills for services provided by CSEC which my insurance company does not reimburse or cover, for any reason.

_____ _____

Patient or Personal Representative Signature Date

I give my permission for CSEC to leave reminders of office visits/procedures on my answering machine.

Yes _____ No_____ Not applicable _____

I give my permission for CSEC to leave a message about my care on my answering machine.

Yes _____ No_____ Not applicable _____

I give my permission for CSEC staff to discuss my care with the following family members:

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Signature: _____ Date: _____

Witnessed by: _____ Date: _____