Endoscopy Center of Ocean County / Endoscopy Center of Toms River
Doctors Tamimi, Collier, Bigornia, Glazier, Mirchandani, Menadier
477 / 473 Lakehurst Road
Toms River, New Jersey 08755
732-349-4422

Facility Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to the facility Endoscopy Center of Ocean County/Endoscopy Center of Toms River (EOC/ETR) for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. I understand that I am financially responsible for payment of all services regardless of any payment issued by my insurance or not. A photocopy of this authorization shall be considered as effective and valid as the original.

X___________________________________ _________________________

Signature of Patient or Guardian Today's Date

Release of Medical Records and Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

X___________________________________ _________________________

Signature of Patient or Guardian Today's Date

Billing Acknowledgement

I understand that EOC/ETR bill for the Facility Fee ONLY: In addition I may be responsible for, and receive a separate bill (when applicable) from:

1) Allied Digestive Health for the Physician's Fee
2) The Laboratory/ Pathologist for any tissue/ biopsy testing
3) The Anesthesiologist for provision of any anesthesia

I further understand that the final determination of whether an exam is considered "screening" or "diagnostic" cannot be made until the results are complete. I have received and understand a copy of "Colonoscopy: Screening, surveillance or diagnostic". I acknowledge that the physician's determination is final and will not be changed for the purpose of reconsideration/overturning of insurance decisions.

X___________________________________ _________________________

Signature of Patient or Guardian Today's Date