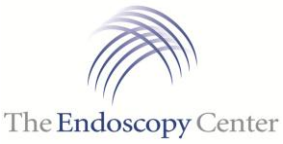

PATIENT FINANCIAL RESPONSIBILITY CONTRACT

Patient Name: _____

Date of Service: _____ CGI _____

TEC _____

_____ I acknowledge that I do not have insurance coverage

Fee $ _____

_____ I acknowledge that I do not have a referral or authorization

_____ I acknowledge that I have a facility copay of $ _____.

I hereby agree to be fully financially responsible and liable for services provided to me today at The Center for GI Health (CGI) *or* The Endoscopy Center (TEC).

I agree to pay my balance of $ _____ in 3 monthly payments of

$ _____.

I agree to notify CGI *or* TEC to discuss any change in the terms of this agreement. If notification is <u>not</u> received, I understand my account may be turned over to a collection agency.

Thank you.

The Center for GI Health
The Endoscopy Center

Patient Signature _____ Date _____

Witness _____

_____ Copy given to patient