Endoscopic Services, P.A.
1431 S. Bluffview, Suite 215
Wichita, KS 67218

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY, PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES, AND PBM CONSENT

Financial Responsibility- I understand I will receive a separate bill for the facility fee, a bill from the physician performing my procedure, a bill for any pathology/lab, and /or a bill for anesthesiology (if applicable). *I agree that I am financially responsible for services provided to me.*

Acknowledgement of Receipt of Patients Rights and Responsibilities- I was informed verbally and in writing of my rights and responsibilities, in advance, of my procedure. *I fully understand my rights and responsibilities.*

Advance Directives Receipt of Information Acknowledgement- I was informed verbally and in writing, in advance of my procedure, about advance directives and this practice's policy on advance directives.

Formulary Benefits Data Consent- I was informed verbally and in writing, in advance of my procedure, about allowing Endoscopic Services, PA to accesses my pharmacy benefits data electronically thru RxHub. *I give permission for Endoscopic Services, PA to obtain formulary information and information about other prescriptions prescribed by other providers using RxHub.*

Patient Signature: _____ **Date**: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____
Relationship to Patient: _____