COASTAL ENDOSCOPY CENTER, LLC
175 Gunning River Road | Building A | Unit 4 | Barnegat, NJ 08005-1436
Tel: (609) 698-0700 Fax: (609) 698-0777

DISCLOSURE FORM

Dear Patient:

You have been scheduled to have your upcoming procedure at **Coastal Endoscopy Center, LLC** (the "Facility").

The following disclosure is made at or prior to the time that the referral is made:

In accordance with Federal Regulations (42 C.F.R> 416.50(a)(ii)) and the Public Law and applicable rules of the State of New Jersey, Board of Medical Examiners (C. 26:2H-12; N.J.A.C. 13:35-6.17) a physician, podiatrist and all other licensees of the Board of Medical Examiners must inform patients of any significant financial interest in a health care service.

The facility is owned {**IN PART**} by Dr. . Accordingly, please take notice that the physician who will be performing your procedure may have a financial interest in the heath care service for which you are being referred.

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

You have the right to enter into and advanced directive. An advanced directive means a written statement of your instructions and directions for health care in the event of your future decision making incapacity. An advanced directive may include a proxy directive or an instruction directive, or both. (N.J.A.C. 8:43A-1.3).

You have the right to make informed decisions regarding your care including the right to make decisions concerning the right to accept, refuse, or choose from alternative of medical and/or surgical treatment.

By signing this disclosure you or your legal representative, acknowledge that: (1) you are receiving this notice prior to the date of your procedure; (2) you have been informed of the financial interests of the practitioners in this office; (3) you voluntarily desire to have your procedure performed at the Facility; (4) you have been informed that part or all of your procedure will be considered "out-of-network," if applicable; (5) you have the right to enter into an advanced directive; and (6) you have the right to make informed decisions regarding your care.

Understood and agreed:

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

Complaints may be lodged with the following:

N.J. Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
P.O. Box 367
Trenton, NJ 08625-0367
Complaint Hotline: 1-800-792-9770
http://www.state.nj.us/health/healthfacilities/index.shtml

Office of Medicare Beneficiary Ombudsman
http://www/medicare.gove/ombudsman/activities.asp