

MONMOUTH GASTROENTEROLOGY, LLC.

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Dear Patient:

You have been scheduled to have your upcoming procedure at **Advanced Endoscopy & Surgical 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 licenses 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 the Physicians of Monmouth Gastroenterology. Accordingly, please take notice that the Physician who will be performing your procedure has a financial interest in the health care service for which you are being referred.

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

(IF APPLICABLE) Please take notice that the Facility is not a participating provider with your insurance carrier. As such, part of all your upcoming procedure will be considered "out-of-network." You will be personally responsible for the co-payment, co-insurance, deductible or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

You have the right to enter into an advance directive. An advanced directive means a written statement of your instructions and directions for health care in the event of your future decision making capacity. An advance 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 alternatives 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 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 advance directive; and (6) You have the right to make informed decisions regarding your care.

Understood & agreed:

Patient Signature

Date

Witness Signature

Date

Printed Name

Printed Name

Complaints may be lodged with the following:

NJ Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 367, Trenton, New Jersey 08625-0367
Complaint Hotline: 1-800-792-9770
<http://www.state.nj.us/health/healthfacilities>

Office of the Medicare Beneficiary Ombudsman
<http://www.medicare.gov/Ombudsman/activities.asp>