Monmouth Gastroenterology
A Division of Allied Digestive Health

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Nadeem Baig, MD **Kenneth Belitsis, MD** **Thomas Fiest, DO**

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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