CSHP
COLORADO SPRINGS HEALTH PARTNERS, P.C.
Ambulatory Surgery Center

Gastroenterology (GI) Laboratory
209 S. Nevada Avenue
Colorado Springs, CO 80903 (719) 636-3555

PLEASE SIGN AND BRING DAY OF PROCEDURE

_____
Patient Chart Number

As a patient of Colorado Springs Health Partners, P.C. (CSHP), I understand my insurance may not/will not pay for services I receive. I also understand that I may be billed separately for any services I receive from a provider (or providers) outside CSHP. I agree to accept full financial responsibility for any medical care and/or ancillary services related to this visit. I am aware that this procedure is being done at the CSHP GI Lab, which is considered an outpatient facility, and I will be charged an outpatient co-payment.

_____
Name of Patient

_____ _____
Insurance Company Name of Primary Care Physician

_____
Signature of Patient, Parent, or Legal Guardian Date

_____
Signature of CSHP Witness Date