THE ENDOSCOPY CENTER OF OCEAN COUNTY
477 LAKEHURST ROAD

THE ENDOSCOPY CENTER OF TOMS RIVER
473 LAKEHURST ROAD

TOMS RIVER, NEW JERSEY 08755

TELEPHONE 732-349-4422
FAX 732-349-8126

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

I hereby acknowledge receipt of the following printed information:

1. Information regarding the **procedure** I am scheduled for. (i.e.: colonoscopy).

2. Brochure regarding the **physicians** of the **Gastroenterologists of Ocean County.**

3. Information sheet regarding the **Endoscopy Center, its ownership, and information on the Center's policies on Advanced Directives.**

4. **Pre-procedure instructions** for the procedure that I am scheduled for.

5. **"Sample" Copies of the Informed Consents** to read over at home.

6. A copy of **Patient Rights and Responsibilities**.

I understand that after reading this information, and asking questions I may have, I will be able to make an informed decision regarding the recommended procedure.

I further understand that if I **cancel my procedure with less than 48 hours notice,** I will be charged a **$100.00 cancellation fee, which is not covered by my insurance.**

_____Date_____

Signature of patient (or guardian)

6/3/03, revised 9/23/03, 9/18/05, 4/13/06, 4/24/09, 10/8/09