



**Michiana
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Inc.**

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Patient Name: _____

Patient DOB: _____

Your physician with **Michiana Gastroenterology** is a part-owner of the **Michiana Endoscopy Center** (the “Center”). Your physician believes the Center is an appropriate setting for certain medical care and services for which you are being referred. Nevertheless, the selection of a specific health care provider always rests with the patient and you may choose to be referred to an alternate setting if you so desire. Your signature below indicates your receipt and understanding of this information.

Patient or Personal Representative Signature*

Date

(*) If signed by Personal Representative, state relationship to Patient:
