ENDOSCOPIC DIAGNOSTIC & TREATMENT CENTER

PATIENT LABEL

PATIENT REGISTRATION

NAME	MARITAL STATUS S M W D ETHNICITY:	DATE OF BIRTH RACE:	
STREET ADDRESS		PHONE (H)	
CITY STATE, ZIP		PERSONAL PHYSICIAN	
OCCUPATION/ EMPLOYER	PHONE	SPOUSES OCCUPATION/ EMPLOYER	PHONE
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	IF UNDER 18 PARENT / GUARDIAN	
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATIONSHIP
S. S. N. EMAIL ADDRESS:		REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)		RELATION	
BILLING ADDRESS		PHONE #	

PAYMENT REQUESTED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	ID#	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	ID#	GROUP #	BENEFIT CODE
MEDICARE #	MEDICAID I.D. #		

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to **Endoscopic Diagnostic & Treatment Center** for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Endoscopic Diagnostic & Treatment Center,** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE • MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PRINT NAME	DATE RECEIVED
PARENT/GUARDIAN	SIGNATURE

ENDOSCOPIC DIAGNOSIS & TREATMENT CENTER

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PATIENT PRIVACY NOTICE

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. Many so we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

The Department of Health and Human Services has established a " Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI) If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ______________________________

Signature: ______________________________ Date: ____________________

ENDOSCOPIC DIAGNOSTIC & TREATMENT CENTER

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PATIENT MEDICAL HISTORY/PRE-ENDOSCOPY ANESTHESIA QUESTIONNAIRE

Date______________

HAVE YOU HAD ANY OF THE FOLLOWING? (Please circle)

Asthma	No	Yes	Emphysema, Bronchitis	No	Yes
Peptic ulcer disease	No	Yes	A cold at present	No	Yes
High blood pressure	No	Yes	Heart trouble	No	Yes
Heart attack	No	Yes	Chest pain, angina	No	Yes
Valvular heart disease	No	Yes	Diabetes	No	Yes
Bleeding or bruising easily	No	Yes	Thyroid disease	No	Yes
Stroke or Paralysis	No	Yes	Arthritis	No	Yes
Kidney disease	No	Yes	Depression or anxiety	No	Yes
Convulsions or epilepsy	No	Yes	Liver disease, jaundice, hepatitis	No	Yes
High Cholesterol	No	Yes			
Blood transfusion	No	Yes	Reaction? ______________		
Glaucoma/Cataract	No	Yes			
A history of cancer?	No	Yes	Type? ______________		
Do you smoke cigarettes now?	No	Yes	Quit? ______________		
Do you drink alcoholic beverages?	No	Yes	Quantity? ______________		
Women: Are you pregnant?	No	Yes			
Possibly?	No	Yes	Last menstrual period? ______________		

PLEASE ANSWER THE FOLLOWING QUESTIONS.

Please list any operations you've had. ______________________________

____

Are you taking any ASPIRIN, COUMADIN, PLAVIX, or ANY OTHER BLOOD THINNER? ______________
Last time taken? ______________________________

Are you taking any ARTHRITIC MEDICATION, VITAMIN E or any HERBAL PRODUCTS? ______________
Last time taken? ______________________________

Have you been advised to take ANTIBIOTICS prior to having any dental work? ______________

Are you ALLERGIC to any medications, food, tape, latex? (Explain) ______________

Are there any other medical problems that we should be aware of? ______________

____

PLEASE TURN AND COMPLETE OTHER SIDE OF PAGE

ENDOSCOPIC DIAGNOSIS & TREATMENT CENTER

PATIENT LABEL

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: ______________________________ Med. Rec. #: ____________________

Physician: ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above named medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize the Endoscopic Diagnostic and Treatment Center to release medical information in the event of any emergency transfer to an Acute Care Facility.

______________________________ ____________________

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named medical facility sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

______________________________ ____________________

Signature of Patient or Authorized Representative Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

______________________________ ____________________

Signature of Patient or Authorized Representative Date

ENDOSCOPIC DIAGNOSTIC AND TREATMENT CENTER
AMBULATORY SURGERY CENTER

Dear Patients,

We would like to inform you that **Endoscopic Diagnostic and Treatment Center** is an out-of-network Ambulatory Surgery Facility for the following insurances:

Cigna
Healthnet
Local Unions
Aetna

As a courtesy to you, our administrative staff will assist you with any necessary paperwork and will file claims on your behalf.

Please be advised that Anesthesia Services, Pathology and your Doctor's Fee are not part of **Endoscopic Diagnostic and Treatment Center** and that your insurance company will be billed separately for these services.

Should you receive a check from your insurance carrier made payable to you for services rendered at this **Facility,** kindly endorse the check(s) and mail them to **Endoscopic Diagnostic and Treatment Center** along with the attached explanation of benefits.

Please speak to our office staff if you have any questions.

I have read the above statement, understand its contents and agree to endorse any checks as described above.

____________________________ __________________________

Patient Signature Date

ENDOSCOPIC DIAGNOSTIC & TREATMENT CENTER
MEDICATION RECONCILIATION FORM

PATIENT'S LABEL

PATIENT NAME: ______________________________ DATE: ______________________

Please include all prescriptions, Over the Counter, Vitamins and Herbal Medications taken routinely Prior to procedure.

DATA SOURCE ☐ Patient ☐ Family ☐ Other Health Facility

ALLERGIES ________________________________ PATIENT TAKES NO MEDS ☐

Medication Name	Dosage	Frequency (When)	Route (How)	Last Dose Taken	√ Continue	√ Discontinue

Please list new medications prescribed for patient at discharge.
____
____

☐ No new medication prescribed.

Signature of Physician ________________________ Signature of Patient ____________________

Signature of Nurse ______________________ Date: ____________ Time: ______________

ENDOSCOPIC DIAGNOSTIC & TREATMENT CENTER

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ACKNOWLEDGMENT OF INTERPRETER

I, ______________________________ hereby acknowledge that I have translated the
(Print interpreter's Name)

Following documents from the Center for the above named patient.

- Patient Registration
- Assignment of Benefits
- Authorization for Release of Information
- Bill of Rights
- Privacy Information
- Consent for Procedure
- Consent for Anesthesia
- Consent for Laboratory Billing
- Patient Medical History/Anesthesia Questionnaire
- Patient Discharge Instructions
- New York State Department of Health's complaint hotline
- Other: ____

______________________________ ______________________________
Interpreter's Signature Date

______________________________ ______________________________
Relationship to Patient Witness' Signature

______________________________ ______________________________
No Interpretation needed Date
Patient's Signature

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ENDOSCOPIC DIAGNOSTIC & TREATMENT CENTER

PATIENT LABEL

CONSENT FOR LABORATORY BILLING

During the course of your procedure, it may be necessary for your physician to obtain and send tissue samples, blood samples or request other laboratory testing. New York State requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Center to receive authorization from the Patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing for the services will go directly to you as the Patient.

Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation.

[ ] Yes, I am giving the laboratory permission to bill my insurance company.

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for payment of services directly to the laboratory.

Signature ______________________ **Date** ______________________

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ENDOSCOPIC DIAGNOSTIC AND TREATMENT CENTER

PATIENT ADVANCE DIRECTIVE ACKNOWLEDGMENT FORM

I, ________________________ acting as (circle appropriate designation) Patient
(Print your name)
Patient's representative, relative, do hereby acknowledge receipt, review, and the opportunity to ask any questions about, the following information:

Advance Directives for Health Care:

- Planning Ahead for Important Decisions
- Definitions for an Advance Directives

I further attest that I have informed the Endoscopy Center of the existence, if any, of instructions pertaining to Advanced Directives, Living Wills, DNR Orders, Health Care Proxy, or other forms of an expression of patient self-determination. I have/will provide a copy of the duly executed instrument and acknowledge that said copy will become a part of the Patient medical record.

I have an Advance Directive: [ ] No [ ] Yes Type:______________________________

I understand and acknowledge that it is the responsibility of the Patient, or his/her representative, to inform the Endoscopy Center immediately of any change in the conditions of the above mentioned expression of Patient self-determination.

______________________________	______________________________
(Print Patient's name)	(Patient, representative, relative) Signature [Circle appropriate one]
______________________________	______________________________
(Date)	(Witness) Signature/Title

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

THE PATIENT HAS THE RIGHT TO:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor.
2. Be treated with consideration, respect and dignity including privacy in treatment.
3. Be informed of the services available and the applicable charges.
4. Be informed of the provisions for off-hour emergency coverage.
5. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
6. Receive an itemized copy of their account statement, upon request.
7. Obtain from their health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
8. Receive from their health care practitioner information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An individual consent shall include, at a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonable foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision.
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of their action.
10. Refuse to participate in experimental research.
11. Voice grievances and recommend changes in policies and services to the Center's staff, the Governing Body and the New York State Department of Health without fear of reprisal.
12. Express complaints about the care and services provided and to have the Center investigate such complaints. The Center is responsible for providing the patient or their designee with a written response within thirty (30) days indicating the findings of the investigation. **The Center is also responsible for notifying the patient or their designee that if the patient is not satisfied by the Center's response, or has a complaint regarding the services provided by the Center, the patient may make a complaint at any time directly to: <u>New York State Department of Health's Centralized Complaint Hotline at 1-800-804-5447; The accrediting agency AAAHC (847-853-6060); or to their Medicare Ombudsman at 1-800-633-4227.</u>**
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. Approve or refuse the release or disclosure of the contents of their medical record to any health care practitioner and/or health care facility except as required as by law or third-party payment contract.
15. Access their medical record pursuant to the provisions of the law.

AS PATIENTS THEY HAVE THE FOLLOWING RESPONSIBILITIES:

1. To provide the Center with accurate medical information.
2. To ask all questions they may have regarding the treatment provided by the Center.
3. To consent by free will to all medical treatments and/or procedures.
4. To inform the Center if the medical procedures or instructions are not understood.
5. To follow after-care instructions as recommended by the Center.
6. To contact their health care practitioner with post-testing questions or concerns.
7. To provide all necessary information regarding third-party payment sources.
8. To observe all the Center's policies and procedures.
9. To keep appointments as scheduled, or advise the Center in a timely manner if any appointment cannot be kept.