

Westchester
Endoscopy Center



PATIENT INSTRUCTION PACKET

Please read the information in this packet at least **5 DAYS** prior to
the time of your scheduled appointment.

Westchester Endoscopy Center
Two Gannett Drive
White Plains, NY 10604
(West Harrison, NY 10604 on GPS)
Telephone: (914) 683-1619
Fax: (914) 694-5660
www.westchesterendoscopycenter.com



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 (West Harrison, NY 10604 on GPS)
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WELCOME NOTICE

Welcome to Westchester Endoscopy Center! The primary goal of the Center is to provide the highest quality medical care to the patients we serve. We are dedicated to ensuring that the physicians and patients have a state-of-the-art endoscopy center with the latest technology and equipment available, and staff committed to providing the best possible support to the physicians and patients.

Westchester Endoscopy Center is accredited by the New York State Department of Health and the Joint Commission on the Accreditation of health Organizations as a freestanding ambulatory surgical care facility for endoscopic procedures.

We are conveniently located off Westchester Avenue between I-684 and the Hutchinson River Parkway, just off I-287 and are easily accessible by train and bus services from the entire greater New York area. If you are driving and wish to use GPS to locate our Center, please enter "West Harrison" in lieu of "White Plains," as we are located at the border.

Westchester Endoscopy Center uses the most up-to-date GI endoscopy equipment including new High Definition (HD) colonoscopies and endoscopies. Our center is fully staffed with experienced, board certified physicians, registered nurses, endoscopy technicians/medical assistants and support staff. Further information can be found on our website at www.westchesterendoscopycenter.com.

Your physician's decision to choose our center for colonoscopy or endoscopic procedure reflects his or her confidence and concern for ensuring the highest quality surgical services for your well-being. We are committed to that goal.

Please follow your physician's instructions for your procedure. Remember to bring someone to accompany you to your procedure and to escort you home. For your convenience, we have enclosed directions to our Center by car and public transportation.

Kindly complete the enclosed forms and bring them with you on the day of your appointment.

Once again, thank you for choosing Westchester Endoscopy Center for your medical procedure!

PATIENT REGISTRATION FORM

Referring Physician: _____

Last Name: _____ First: _____ MI _____

SSN: _____ DOB: _____ Sex: [] M [] F

Marital Status: [] Single [] Married [] Widowed [] Divorced

RACE: American Indian Asian Black or African American
 Native Hawaiian or Pacific Islander White Other Race – Not listed above

ETHNICITY: Hispanic or Latino Ethnicity Non Hispanic or Latino Ethnicity

Phone: Home _____ Work _____ Cell: _____

Address: _____
Street City State Zip

Emergency Contact: _____

Name Phone Relationship

Primary Insurance: _____ Ins. ID No. _____

Ins Ph: _____ Address: _____

Insured Name: _____ SSN _____ DOB _____

Secondary Insurance: _____ Ins. ID No. _____

Ins Ph: _____ Address: _____

Insured Name: _____ SSN _____ DOB _____

Insurance Verification: Date _____ Time: _____ Verified by: _____

Procedure Scheduled Date: _____ Time: _____

Parent or Guardian Information (if applicable)

Legal Name _____ SS#: _____

DOB: _____ Sex: _____ Relationship to the Patient: _____ Home

Ph: _____ Work _____ Cell _____

Patient Acknowledgement

The information provided above is true to the best of my knowledge. I also acknowledge receiving a copy of the Center's Notice of Privacy Practices, Patients' Bill of Rights, ownership disclosure and advance directives.

Appointment Cancellation Notice:

In order to ensure access to care to all patients, the Center requires all patients to give 48 hours notice for any cancellations. If you fail to provide 48 hours notice you will be charged a \$100 administrative fee.

Signature (must be of 18 years or older): _____ Date: _____

PRE-PROCEDURE PATIENT QUESTIONNAIRE

NAME: _____ REFERRING MD: _____

- 1. Do you have any other medical conditions we should be aware of?
If yes, please explain. Yes _____ No _____
- 2. Do you take any medication regularly?
If yes, please complete the medication list attached. Yes _____ No _____
- 3. Do you have any ALLERGIES to medications or drugs?
If yes, please list. _____ Yes _____ No _____
- 4. Do you have any food allergies? i.e. EGGS or SOY? Yes _____ No _____
- 5. Do you take ASPIRIN-LIKE products on a regular basis?
(Advil, Motrin, Naprosyn, Clinoril, Vioxx, Celebrex)
If yes, these products must be discontinued 72 hours prior to the procedure. Yes _____ No _____
- 6. Do you take COUMADIN or any other ANTI-COAGULANT medications? Yes _____ No _____

If yes, please discuss this with your physician, as this must be discontinued 5 days before the procedure.
- 7. Do you have a history of DIABETES? Yes _____ No _____
- 8. Do you take insulin? Yes _____ No _____
- 9. Have you ever been told that you have a HEART condition? Yes _____ No _____
- 10. Have you ever been told that you had RHEUMATIC HEART DISEASE
or MITRAL VALVE PROLAPSE? Yes _____ No _____
- 11. Have you ever been told to take ANTIBIOTICS prior to a procedure? Yes _____ No _____
- 12. Have you ever had a BLEEDING problem? Yes _____ No _____
- 13. Have you ever had SURGERY?
If yes, please explain. _____ Yes _____ No _____
- 14. Have you ever had any problems with anesthesia?
If yes, please explain. _____ Yes _____ No _____
- 15. Have you ever had an ENDOSCOPIC procedure?
(Colonoscopy or Gastroscopy)
If yes, when, where and what was the result? Yes _____ No _____

Completed By: _____

Date: _____

PREADMISSION MEDICATION LIST VERIFICATION AND ORDER FORM (Medication Reconciliation)

Source of Medication list: (check all used)

- Patient medication list
- Patient/Family recall
- Pharmacy _____
- Primary care physician list
- Previous discharge paperwork
- Medication Administration Record from

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC AND HERBAL MEDS

MEDICATION HISTORY RECORDED/VERIFIED BY: _____

CIRCLE C to continue OR DC to discontinue

DATE RECORDED: _____					PHYSICIAN ORDER	PHYSICIAN ORDER	
MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg,)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	Continue on Admission	Continue on Transfer	Complete on Discharge
1.					C DC		C DC
2.					C DC		C DC
3.					C DC		C DC
4.					C DC		C DC
5.					C DC		C DC
6.					C DC		C DC
7.					C DC		C DC
8.					C DC		C DC
9.					C DC		C DC
10.					C DC		C DC
11.					C DC		C DC
12.					C DC		C DC
13.					C DC		C DC
14.					C DC		C DC

Do not scan or take off orders without MD/NP/PA signature

M.D. Signature: _____

Print Name: _____

Nurse Signature: _____

Date/Time: _____

PATIENT MEDICAL HISTORY/ANESTHESIA QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____ Height: _____

PLEASE CIRCLE YES OR NO

Are any of your teeth loose, weak, or broken? No Yes
 Are you taking any medicines/herbal preparations? No Yes
 If so, what? _____
 Are you allergic to any medications, food, tape, latex? No Yes
 If so, what? _____
 Do you take any drugs for non-medical use? No Yes
 Do you smoke cigarettes now? No Yes
 If no, did you previously smoke or quit? No Yes
 Do you drink alcoholic beverages daily or frequently? No Yes

DO YOU USE:

Hearing Aid, Glasses
Contact Lenses,
Dentures, Pacemaker
Cane or Walker

HAVE YOU HAD ANY OF THE FOLLOWING?

Asthma	No	Yes	Emphysema	No	Yes
Frequent cough or sputum	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	Stroke	No	Yes
Paralysis or arm/leg weakness	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
Hiatal hernia, gastroesophageal reflux	No	Yes			
Blood transfusion reaction	No	Yes - If so, what? _____			

Have you or anyone in your family had complications from anesthesia? No Yes
If so, explain: _____

Women: Are you pregnant? No Yes **Possibly?** No Yes

√ All women in child bearing age are required to have pregnancy test done unless they have undergone a Surgical procedure (Please List) that will prevent them from being pregnant.

List all previous operations & year: _____
 I was instructed not to eat, drink, or take any medications (unless specified by my physician) after midnight last night and that I have followed those instructions.
 I have completed my bowel prep. N/A
 I have made arrangements to have an adult drive me home. I understand that I will not be released by myself or with a minor. I do not plan to drive a car or even take a cab alone.
 I agree that the Endoscopy Center is not responsible for, any valuables that I have elected to bring.

√Do we have permission to speak to the person accompanying you regarding your condition? Yes No
Name of person: _____ Waiting Please call at (____) _____

VALUABLES RELEASE

I agree that the Center is not responsible for any valuables that I have elected to bring.

Signature of Patient

Date

Reviewed by Anesthesiologist

Date

PREGNANCY TEST POLICY

It is the policy of Westchester Endoscopy Center Center that all the female patients who are in child bearing age and generally below fifty (50 years) will have a pregnancy screening urine test prior to the procedure. This testing is done to minimize the risk of potential adverse effects on a developing fetus.

You will not be required to have the pregnancy testing in the event you have had a procedure that prevents you from being pregnant such as sterilization procedure or hysterectomy etc. In that case please list the procedure you have had. Being on a birth control pill does not exclude you from having a pregnancy test done.

DECLINATION OF URINE PREGNANCY TEST

I am declining the Pre-procedure Urine pregnancy Test because I have had the following procedure:

OR

I declare that I am not pregnant. I acknowledge that I understand the risks the fetus may be exposed to as a result of anesthesia if I were to be pregnant. With full knowledge of these risks, I am declining the urine pregnancy test offered to me by Westchester Endoscopy Center. If I subsequently discover that I was pregnant and the baby suffered any anesthesia related complications, I hold Westchester Endoscopy Center and all service providers at Westchester Endoscopy Center harmless because I am declining the Urine Pregnancy Test.

Patient Signature: _____

Date: _____

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION

Name: _____ SSN: _____

Physician: _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize and direct Westchester Endoscopy Center, having treated me to release to governmental agencies, insurance carriers, or others who are financial liable for my medical care, all information needed to adjudicate claims and make payments for such Medicare care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Westchester Endoscopy Center, LLC to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the Westchester Endoscopy Center, LLC to release all my medical records pertaining to that transfer or admission.

Signature of Patient or Authorized Representative

Date: _____

ASSIGNMENT OF BENEFITS

I hereby assign and transfer over to the Westchester Endoscopy Center such monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financial 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 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 intermediates or carriers any information needed for this or a related Medicare claim. I authorize the physician or organization furnishing the services to me to submit a claim to Medicare or intermediaries for the services provided to me. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician services to the physician or organization furnishing the services to me.

Signature of Patient or Authorized Representative

Date: _____

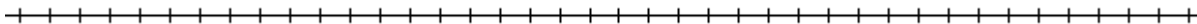
CONSENT FOR LABORATORY BILLING

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. 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 are self-pay patient, and have a financial hardship, the hospital will bill you at a discounted rate.

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.
- I do not have insurance. I am aware that if a biopsy is taken, I shall receive a separate bill from the White Plains Hospital or other Lab to which the biopsy is sent.

Patient Signature: _____ Date: _____



CONSENTIMIENTO PARA LA FACTURACIÓN DE LABORATORIO

Durante el curso del procedimiento, puede ser necesario que su médico, tenga que obtener y enviar muestras de tejido, las muestras de sangre o solicitar otras pruebas de laboratorio.

El Estado de Nueva York requiere que los laboratorios clínicos para facturar directamente a los pacientes por sus servicios de pruebas. Por lo tanto, es necesario que el Centro reciba la autorización del paciente con el fin de que podamos permitir el laboratorio para facturar a su compañía de seguros. Si usted es un paciente de pago propio, y tienen una dificultad financiero, el hospital le facturará a un precio reducido.

Por favor completar signo abajo para que nuestra práctica dirigir esta cuestión de manera adecuada.

Gracias por su cooperación.

- Sí, estoy dando el permiso de laboratorio para la cuenta a mi compañía de seguros.
- Yo no tengo seguro y que soy consciente de que soy responsable por el pago de los servicios directamente al laboratorio.

Firma _____ **Fecha** _____

ESCORT POLICY

Please note that your procedure cannot be performed unless your escort home is verified.

As a matter of patient safety, the Westchester Endoscopy Center enforces the New York State Ambulatory Surgical Center requirement that all patients having a procedure in our center have an escort; that is companion, family member or friend to accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888-943-8435) to arrange for a care partner to accompany you from your procedure.

Please be advised that you cannot drive for 24 hours after your procedure if you have had monitored anesthesia care or sedation.

For additional information and to make arrangements for a care partner, you can visit the following website: www.partnersincareny.org

If the patient's escort does not arrive after the procedure, the Center does not take any responsibility for transporting the patient back home or providing an escort. In such cases after clearance from the attending physician, the patient will be discharged against medical advice. The patients are instructed to call 911 and go to the nearest emergency room in case of any emergency and also inform their physician's office.

I _____, have read the policy and fully understand that the procedure will not be performed unless I confirm I have an escort back home in the form of family or a friend. Taxi is not an acceptable form of transport back home unless I have a family or a friend accompanying me.

Patient Signature: _____ Date: _____

Escort Name: _____ Phone Number: _____

PROCEDURE INFORMATION SHEET

An upper endoscopy or **EGD (EsophagoGastroDuodenoscopy)** involves the insertion of a lighted flexible tube, called an upper endoscope, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

A **colonoscopy** involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of an electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure there are risks that may occur with any surgical or medical procedure. There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

Further information about these procedures can be obtained at the following organization websites:

The American College of Gastroenterology:

www.acg.gi.org/patients/

The American Society for Gastrointestinal Endoscopy:

www.aske.org/

PERSONAL POSSESSIONS NOTICE

Westchester Endoscopy Center will provide you with a private locker to safely keep your personal belongings during the procedure. We strongly encourage you to use the locker provided. Please do not bring jewelry, laptops, iPods or any other valuables when you come to the center.

Please note that Westchester Endoscopy Center assumes not responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.

Frequently Asked Questions (FAQ's)

The following list of questions and answers may assist you in preparing for your procedure:

1. **Q) I am having an upper endoscopy. Do I have to do anything to prepare for this procedure?**
A) There is no specific preparation but you should not eat or drink anything after midnight the night before the test.
2. **Q) My procedure is scheduled for the afternoon. Can I eat or drink anything the morning of the procedure?**
A) You should not eat anything after midnight. You may have up to 1 cup of clear liquid four hours prior to your scheduled arrival time at our endoscopy suite.
3. **Q) Will my procedure be painful?**
A) No. The Center is fully staffed with board-certified anesthesiologists to ensure that your procedure is comfortable.
4. **Q) How long will I be at the endoscopy suite?**
A) You will be at our suite approximately 1 ½ hours in total.
5. **Q) Do I have to bring an escort with me?**
A) We require that you have an escort to take you home; however, the escort does not have to be present upon arrival but must be present before you are discharged from our suite. Also you should not drive for 24 hours after your procedure if you have received monitored anesthesia care or sedation.
6. **Q) My doctor has all my insurance information. Do I need to bring my insurance card and billing information?**
A) Yes. Westchester Endoscopy Center is a separate entity and we require that you bring your all insurance cards and your state or federal photo ID
7. **Q) Will I receive a bill?**
A) Yes. We will bill your insurance company or HMO directly first. You will be billed for your co-payment, deductible and co-insurance. *** Please note that some insurance companies may send payment directly to you for the facility and anesthesia service. We expect that you will forward this payment directly to our office.**
8. **Q) Do I take my heart medications on the day of my procedure?**
A) In general, you can continue to take prescribed medications before and after gastrointestinal endoscopy without modification. Essential medications may be taken on the day of your procedure with a small amount of clear liquid. There are some types of cardiovascular medications, however, that should not be taken on the day of your procedure; these include diuretics, ACE inhibitors, and angiotensin II receptor blockers. If you are unsure if the medications you take fall into these categories, please ask your physician or consult the following website: www.webmd.com/drugs.
9. **Q) I am a diabetic. Should I take my medication on the day of my procedure?**
A) In general, diabetic medication should **not** be taken on the day of your procedure. ***There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary physician.*** A finger stick blood sugar will be obtained by the our staff to ensure proper management of your blood sugar during your procedure. When the procedure is over and you have resumed a normal diet, your usual diabetic regimen should be resumed.
10. **Q) I have been told to take prophylactic antibiotics prior to dental work. Do I need to take antibiotics before my endoscopic procedure?**
A) With rare exceptions, the procedures performed at our suite do **not** require the administration of prophylactic antibiotics. If, however, you are advised by your physician to take antibiotics prior to gastrointestinal endoscopy, you may take them orally, 1 hour prior to the procedure, with a small amount of clear fluid. If you require antibiotics and have not taken them prior to the procedure, please inform the our staff and the antibiotics will be given intravenously.
11. **Q) I take aspirin, or anticoagulants or other blood thinners. Do I need to stop these medications before my procedure?**
A) In general, aspirin, anticoagulants and other blood thinners should be stopped at least 3 days prior to your procedure. This is to reduce the chance of bleeding if biopsies are obtained or polyps are removed. ***There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary physician.***
12. **Q) What if I am pregnant or may be pregnant – should I undergo gastrointestinal endoscopy?**
A) If you are pregnant, you should consult with your physician about whether you should undergo gastrointestinal endoscopy. If you are a woman of child-bearing age the Westchester Endoscopy Center Center requires you to have a pregnancy test done prior to your procedure to rule out a pregnancy, unless you have undergone a sterilization procedure or other surgical procedure such as hysterectomy that will prevent you from being pregnant.
13. **Q) I am breast feeding my baby. Is the procedure safe for my baby?**
A) In general, women who are breast feeding may safely undergo gastrointestinal endoscopy – the administered anesthetic is not excreted in significant quantities in breast milk. Some mothers elect to store milk via a breast pump and feed the child with the pumped milk on the day of the procedure. Normal breast feeding may resume the following day.

OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services.

This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to you home or place of work. Statutory authority; *Public health law, §238 a (10)*

The Following Physicians Are the Owners of this procedure suite:

Jack Rosemarin, M.D., F.A.C.G.
Alfred Roston, M.D., F.A.C.G.
Charles Noyer, M.D., F.A.C.P.

I, _____, confirm that I have read and fully understand the above statements that have been presented/told to me in this document.

Signature

Date

FINANCIAL POLICY

Westchester Endoscopy Center is a freestanding ambulatory surgical center [ASC] subject to New York State regulations. It is not associated with your doctor's office and has separate financial and billing policies and procedures. Please read the following information about our Financial Policy and sign prior to scheduling your procedure at the Westchester Endoscopy Center.

Components of service fee:

1. Facility fee – billed by Westchester Endoscopy Center
2. Physician fee – billed by the doctor's office
3. Anesthesia fee – billed by anesthesia provider
4. Pathology fee – billed by the pathology lab, applies only if biopsies were taken.

1) Call your insurance to determine network participation, coverage, copay and deductibles. Westchester Endoscopy Center is in network with most major insurance carriers. However, due to the expansion of insurance plans, and products within insurance plans, it is not possible for the Center to determine coverage for procedure or network participation with all possible insurance carriers. Therefore, determination of your benefits is eventually your responsibility. We will make good faith effort.

2) If Westchester Endoscopy Center participates with your insurance plan, the fees for your services will be billed to your insurance plan, unless you tell us otherwise. However, you are responsible for the payment of your deductible, copayments and/or co-insurance before the day of the procedure. These fees cannot be waived. Our staff can only provide an estimate of the cost. If you are overpaid, you will receive a refund within 30 days of your procedure. If under paid, you will receive an additional bill.

3) If Westchester Endoscopy Center does not participate with your insurance plan, Westchester Endoscopy Center will bill your insurance plan on your behalf as a courtesy and you will also receive a bill at the same time. If you have "out-of-network" coverage, your insurance plan may cover a part of this charge. You are responsible for the payment of your deductible as well as any unpaid balance.

4) If your insurance sends the payment for services directly to you, you are responsible for forwarding the check directly to Westchester Endoscopy Center. Be advised that not remitting the payment to NYE constitutes a breach of contract and NYE will pursue all legal remedies available to obtain such payment.

5) Westchester Endoscopy Center participates with the Medicare program. If you have Medicare coverage, you will be responsible for payment of the unmet deductible and the remaining 20 percent of the approved charge. Please be prepared to pay these fees at the time of your procedure.

6) Self-pay - If you are a self-pay patient, you must pay at least 24 hours before services are rendered. Unless you are paying a bundled fee, the anesthesiologist and the gastroenterologist who perform the procedure will bill separately for their services. If biopsies were taken, you will receive additional bill from the pathology lab.

7) Cancellations and no show: The Center requires all patients to give 48 hours-notice for cancellations due to any reasons. If you fail to provide 48 hours-notice you will be charged a \$100 administrative fee.

8) Cancellations after admissions: If you are discharged before the procedure due to non-medical reasons, such as not having a ride, or failure to follow prep instructions, you will be considered same as no show or cancelled without proper notice and charged a \$100 administrative fee. If you fail to pay this administrative fee, you may be discharged from care.

Signature of Patient or Responsible Party

Date

POLICY ON ADVANCE DIRECTIVES

Most procedures performed in this facility are considered minimal risk. Of course, no procedure is completely without risk. You will discuss the specifics of your procedure with your physician who will advise you about any associated risks.

Therefore, it is our policy, regardless of the contents of an Advance Directive or instructions from a Health Care Surrogate or Power of Attorney, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. The acute care hospital will order further treatment or withdrawal of treatment measures in accordance with your wishes, Advance Directive or Health Care Power of Attorney.

NEW YORK STATE LAW

New York State Law allows the patients to provide physicians "Advance Directives" under "Patients' Rights in State of New York". For more information and relevant forms please visit http://www.health.state.ny.us/professionals/patients/patient_rights/

Living Will: A Living Will is a document that contains your health care wishes and is addressed to unnamed family, friends, hospitals and other health care facilities. You may use a Living Will to specify your wishes about life-prolonging procedures and other end-of-life care so that your specific instructions can be read by your caregivers when you are unable to communicate your wishes.

A Health Care Proxy is a person who is named by you to make health care decisions on your behalf if you are no longer able to do so. You may give this person (your agent) authority to make decisions for you in all medical situations. Thus, even in medical situations not anticipated by you, your agent can make decisions and ensure you are treated according to your wishes, values and beliefs. The New York Health Care Proxy Law allows you to appoint someone you trust - for example, a family member or close friend - to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes.

Medical Orders for Life Sustaining: To enable physicians and other health care providers to discuss and convey a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, the Department of Health has approved a physician order form (DOH-5003), the Medical Orders for Life Sustaining Treatment (MOLST) that can be used statewide by health care providers and facilities. The form can be used to issue any orders for life-sustaining treatment for general hospital inpatients and nursing home residents. In the community, the form can be used to issue a non-hospital Do Not Resuscitate (DNR) or Do Not Intubate (DNI) order, and in certain circumstances, orders concerning other life-sustaining treatment.

PATIENT'S ACKNOWLEDGEMENT

I _____, acknowledge having been explained the policy on advance directives and agree to suspend these directives until I leave this facility. I have also been provided with a description of applicable state laws pertaining to Advance directives.

(Print Patient's Name)

(Patient, Representative, Relative) Signature
[Circle Appropriate One]

(Date)

(Witness) Signature/Title

PATIENTS 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 applicable charges at the Center.
4. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
5. Be informed of the provisions for after hours and emergency care.
6. Receive an itemized copy of his/her account statement, upon request.
7. Obtain from his/her Physician, or the Physician's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand and to participate in decisions involving the planned treatment. When it is medically inadvisable to give such information to a Patient, the information is given to a person designated by the patient or legally authorized representative.
8. Receive from his/her Physician information necessary to give informed consent prior to the start of any procedure or treatment or both. An individual consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably 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 his/her action.
10. Refuse to participate in experimental research.
11. Voice grievances and recommend changes in policies and services to the Center's staff, the operator and the New York State Department of Health without fear of reprisal.
12. Express complaints about the care and services provided to the Administrator at (914) 683-1619 and to have the Administrator investigate such complaints. If the patient is not satisfied by the Center's response, the patient may complain to the Westchester County Department of Health at (914) 813 –

5048 or to the Joint Commission at (800) 994 - 6610

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 his/her medical record to any Health Care Practitioner and/or Health Care Facility except as required by law or third-party payment contract.
15. Access their medical record pursuant to the provisions of the law.
16. Expect the Physicians and staff to be fully qualified to provide the necessary care and treatment.
17. Change primary or specialty Physicians, if other qualified Physicians are available.
18. Be informed regarding the absence of Physician malpractice insurance coverage.
19. To execute an Advance Directive. However, because of the nature of services the Center provides, the NYEC does not accept advance directives even though these have been executed and a copy provided to the center.
20. To receive pain management services.

The patient has the following responsibilities:

1. To provide the Center with accurate and complete medical information.
2. To ask all questions you may have regarding the treatment provided by the Center.
3. To consent by free will to all procedures or treatments.
4. To inform the Center if procedures or treatments are not understood.
5. To follow after-care instructions as recommended by the Physician.
6. To contact his/her Physician 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, Procedures and Regulations.
9. To keep appointments as scheduled, or advise the Center in a timely manner if an appointment
10. To be considerate of other Patients and Personnel and respect the property of others and the Center.

With Medicare, you have special rights and protections. Please visit their website for additional information @ <https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

Patient Name: _____ Signature: _____ Date _____

Notice of Privacy Practices

- A. Notice:** This notice describes the privacy practices of NYEC, LLC. We are required by law to maintain the privacy of your personal health information. We must provide you with notice of our legal duties and privacy practices with respect to personal health information. We must abide by the terms of the notice of privacy practices that is currently in effect. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
- B. Permissible uses and disclosures without written consent:** The following disclosures are permitted by law to without your written consent.
- 1. Medical Treatment:** We may need to share information about you with other healthcare providers such as other physicians including referring physicians, nurses or healthcare professionals entering information into your medical records relating to your medical care and treatment in order to provide care to you. We may share information about you including x-rays, prescriptions and requests for lab work.
 - 2. Payment:** We may need to disclose information about the treatment, procedures or care our practice provided to you in order to bill and receive payment for services we provided. We may share this information about you, with an insurance company, a third party responsible for payment, or a collection agency or your employer if your employer is responsible for paying the claim.
 - 3. Healthcare Operations:** We may use and disclose your personal health information to Business Associates who need to use or disclose your information to provide a service for our medical practice, such as our billing company or software vendors who provide assistance with data management on our behalf or a company that may assist us with compliance efforts.
 - 4. Disclosure to Relatives:** Close Friends, or Care givers: We may disclose PHI to a member of your family, other relative, a close friend, or any other person identified by you, when you are present, or otherwise available, prior to disclosure. If you object to such disclosures, please notify the Administrator, or care giver immediately. Request may be verbal or in writing. If you are not present, or you are incapacitated, or in an emergency situation, we may exercise our professional judgment to determine whether PHI should be disclosed in your best interest to your relative, close friend or a caregiver. In such circumstances, we will disclose minimum necessary information. We may also notify such persons your location and general health condition.
 - 5. Required by Law:** We will disclose medical information related to you if required to do so by state, federal or local law.
 - 6. Public Health Activities/Risks:** Your medical information may be disclosed to a public health authority that is authorized by law to collect or receive such information for public health activities. Certain disclosures may be made for public health activities in the following circumstances: (a) to prevent or control disease, injury or disability (b) to report reactions to medications or product defects; (c) to notify individuals of product recalls; (d) to notify a person who may have been exposed to a communicable disease or at risk of contracting or spreading a disease or condition; (e) if our practice reasonably believes a person is the victim of abuse, neglect, or domestic violence, we may disclose personal health information to the appropriate authority. We will only make this disclosure if you agree to the disclosure or we are required or authorized to do so by law without your permission.
 - 7. Appointment Reminders or Treatment Alternatives:** Our practice may use and disclose medical information about you to provide you with reminders that you are due for care or you have an upcoming appointment; to provide you with information on treatment alternatives or other health related benefits that may be of interest to you. We may contact you by phone, fax or e-mail. We will make every effort to protect your privacy when leaving a message for you and try to reveal as little confidential information as possible (e.g., when leaving a message on your answering machine that may be heard by others).
 - 8. Research:** We may disclose your personal health information for research purposes without your written authorization if requirement for consent has been waived by a Review Board who has assessed the effect of the research protocol on your privacy rights and interests and certified that there are adequate controls in place to protect your information from improper use and disclosure.
 - 9. To Avert Serious Threat to Health or Safety:** If our practice believes, in good faith, that a use or disclosure of your medical information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may disclose your medical information.
 - 10. Worker's Compensation:** We may release medical information about you for work-related illness or injury for workers' compensation or other related programs.
 - 11. Health Oversight Activities:** Your personal health information may be disclosed to federal, state or local authorities as part of an investigation or government activity authorized by law. This may include audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions or other activities necessary for the oversight of the health care system, government benefit programs and compliance with government regulatory programs or civil rights laws.
 - 12. Law Enforcement:** We may disclose your personal health information to law enforcement individuals if we are required to do so by law. We may also disclose medical information about you in compliance with a court order, warrant or subpoena or summons issued by the court. We will make best efforts to contact you about these types of requests so that you can obtain an order restricting or prohibiting disclosure of the information requested. We may also use such information to defend ourselves in actions or threatened actions that may be brought against our practice.
 - 13. Coroners, Medical Examiners and Funeral Directors:** We may release personal health information to a coroner or medical examiner for the purposes of identification, determining cause of death or other duties as authorized by law. We may also release medical information to funeral directors as necessary to carry out their duties with respect to the deceased.
 - 14. Organ, Eye, Tissue Donation:** If you are an organ donor, we may disclose your personal health information to organ procurement organizations, or other entities that facilitate tissue donation or transplantation.
 - 15. Inmates:** If you are an inmate of a correctional institution or within the custody of law enforcement officials, we may disclose medical information about you to allow the institution to provide you with medical care, to protect the health and safety of yourself and others, or for the safety and security of the correctional institution.
- C. Disclosures requiring consent:** Disclosure for any other purpose than listed above requires your prior authorization.

- D. Marketing Communication:** we may obtain your written permission for sending you any marketing material. However no permission is needed to provide you with marketing information face to face.
- E. Special Authorization:** Confidential information related to your HIV status will never be disclosed to anyone without your prior written consent. This consent will be obtained on the NYS approved consent form.
- F. Right to Revoke Authorization:** You have the right to revoke any or all authorization at anytime.
- G. Patient Rights** You have the following rights with respect to your personal health information:
1. **Right to Receive Personal Health Information Confidentially.** You have the right to receive confidential communications of your personal health information by alternate means or at alternate locations. We will attempt to accommodate all **reasonable** requests. Please be specific as to how or where you wish us to communicate with you.
 2. **Right to Inspect and Copy.** You have the right to inspect and copy your medical record that has been created to treat you and is used to make decisions about your care. This includes medical and billing records. Records related to your care may also be disclosed to an authorized person such as a parent or guardian upon proper proof of a legitimate legal relationship. You must submit your request in writing to inspect and copy your records. If you would like to copy your records, our practice may charge you fees for the cost of copying records, mail or other minimal costs associated with your request.
 3. **Right to Amend.** If you think there is information in your record that may be inaccurate or incomplete, you have the right to request an amendment or clarification of information in your record. Please note that we will not change information created by third parties, if the information is not part of the medical information kept by our practice or we believe the information you provided to us is inaccurate or incomplete. We reserve the right to deny your request if we have reason to believe the information is accurate. Your request to make an amendment to your record must include the following and may be refused if the following elements are not met: a) Submit your request in writing; b) Describe what you would like the amendment to say and your reasoning for why the change should be made; c) The amendment must be dated, signed by you and notarized.
 4. **Right to Restrict Uses and Disclosures.** You have the right to request restrictions on how our practice makes certain uses and disclosures of your personal health information for treatment, payment or healthcare operations. You may restrict how much information we may provide to family members regarding your treatment or payment for your care. You may also restrict certain types of marketing materials related to your care or treatment. **We are not required to agree to your request or we may not be able to comply with your request, but we will do all that we can to accommodate your request. If we agree to your request, we must comply. However, if the information is required to provide emergency treatment to you, we will not comply.** Your request must be in writing and include the following: a) what information you would like to limit; b) whether you want to limit our use, or disclosure or both; c) to whom you want the limits to apply (e.g., disclosures to parents, children, spouse, etc.)
5. **Right to an Accounting of Uses and Disclosures.** You have the right to receive an accounting of the disclosures of your personal health information that our practice makes for purposes other than treatment, payment or healthcare operations. All requests must be submitted in writing. All requests must state a time period **not longer than six (6) years back.** You must state whether you would like the accounting in electronic or paper form. One request in a twelve-month period will be provided to you at no charge. We may charge you a fee for all additional requests within a twelve-month period. We will notify you as to the cost of fulfilling your additional request and allow you the opportunity to modify it before fees are due. All requests should be submitted to the reception desk for appropriate processing.
 6. **Right to Copy of Notice.** You have the right to obtain a copy of our notice of privacy practices upon request at any time. Please call us at (914) 683-1555 for a copy or ask for a copy at the reception desk.
- H. Changes to this Notice.** We reserve the right to change the terms of this notice and to make the new notice provisions effective for all personal health information we already have about you and may obtain in the future. If we change our notice, we will post notice of this change thirty (30) days prior to making the change effective. All revised notices will be posted on our website and promptly posted and made available to you in our waiting room. You may also request a current Notice when you visit our office. Changes to our notice will only be effective on the date that is reflected at the bottom of the last page on the revised Notice.
- I. Practice Contact.** If you would like more information about this notice, please contact the Administrator at (914) 683-1555. If you have any complaints regarding our privacy practices, please address your complaint to the administrator in writing and follow the designated complaint process below.
- J. Complaints.** If you believe your privacy rights may have been violated or you become aware of a privacy concern you would like to report to our practice, you may file a complaint with the Privacy Officer (Administrator) in writing and include the following information: Name and Address; Social Security Number or Other Patient Identification Number; Detailed description of the circumstances surrounding your complaint including dates, times and any relevant information to help us understand your complaint; Contact information; and Signature and Date. Please allow fourteen (14) business days for an answer from our practice regarding your complaint. If you are not satisfied with our response to your complaint, you may notify the Secretary of the Department of Health and Human Services.
- K. Non Retaliation:** Please note, all concerns or complaints regarding your personal health information are important to our practice. There will be no retaliation against you for filing a complaint with our office.
- L. Additional Privacy Protections.** Our practice is committed to protecting your privacy and for the proper use and disclosures of your personal health information. For example, if you treat patients with particularly sensitive conditions, even though the law allows you to disclose the information for various reasons, you will not do so unless required by law.
- M. Electronic Notice.** We are also required to prominently post our Notice of Privacy Practices on our medical practice Website. You can find this notice at <http://nyendoscopycenter.com/>

Effective Date: April 1, 2003. **Revision Date:** Feb 15, 2011

Patient Name: _____ Signature: _____ Date _____