ARIZONA ENDOSCOPY CENTER
1410 EAST McDOWELL ROAD
PHOENIX, ARIZONA 85006
(602) 716-9655 – MAIN LINE
(602) 258-1743 – BILLING OFFICE

You have been scheduled for a procedure at Arizona Endoscopy Center. Enclosed is your paperwork. Listed below are some important instructions.

1. Please read, complete, sign and date all of the paperwork in this packet. **BRING THIS PACKET WITH YOU ON THE DATE OF YOUR PROCEDURE. DO NOT FAX OR MAIL PAPERWORK AHEAD OF TIME.**

2. Because it is patient's responsibility to know your benefits, we ask that you contact your insurance company to verify coverage. If you still have questions regarding financial responsibility, please contact the Billing Office for an estimate the **day prior to your procedure date.** Your copay is expected at the time of service. If you have a deductible and/or coinsurance, Arizona Endoscopy Center will require the patient or responsible party to leave a credit or debit card number on file as a guarantee of payment for all estimated balances.

3. Arrive 45 minutes prior to your scheduled appointment time. Please **DO NOT** bring any **PERSONAL** items with you. Examples are: computers, iPads, iPods, cell phones, large totes or purses, backpacks, jewelry, etc. If you choose to bring these items with you, they will have to remain in the lobby with the person who accompanied you. The facility will not be responsible for these items.

   The ONLY items you need to bring with you are your PAPERWORK, INSURANCE CARD(S), IDENTIFICATION and FORM OF PAYMENT.

4. You **must** have someone to drive you home and **stay** with you after the procedure. This is to ensure your **safety** after the procedure due to the sedation you will receive.

5. Please plan to be at the Center approximately 1-1/2 to 2 hours.

We look forward to seeing you. Please call us with any questions at the numbers above.

ARIZONA ENDOSCOPY CENTER

Patient's Rights and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/her record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and to support participation of the caregiver in decisions affecting medical treatment.

PATIENT RESPONSIBILITIES:

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- To accept personal financial responsibility for any charges not covered by their insurance.

If you need an interpreter:

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

PATIENT'S COPY. PLEASE REMOVE FOR YOUR RECORDS

Arizona Endoscopy Center

FORM-MULTIPLE AUTHORIZATION

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Arizona Endoscopy Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior my surgery/procedure that the physicians who perform procedures/services at Arizona Endoscopy Center may have an ownership interest in Arizona Endoscopy Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Arizona Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my procedure. I have also received information regarding Arizona Endoscopy Center policies pertaining to ADVANCE DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

Signature of Patient or Responsible Party _____ Print Name _____

Relationship to Patient _____ Date Signed _____

Patient Payment Policy

Thank you for choosing Arizona Endoscopy Center as your medical provider. We are committed to providing you with quality health care. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to treatment.

1. It is your responsibility to tell us in advance if your insurance company requires precertification for your procedure(s). If you are not insured by a plan we participate with, payment is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage.
2. All copayments are due at the time of service. This agreement is part of your contract with your insurance company. Failure on our part to collect copayments from patients can be considered fraud. A guarantee of payment will be required for any deductible and/or coinsurance. Arizona Endoscopy Center will be expecting you to leave a credit card/debit card # on file for the estimated patient portion. **Any questions please contact our billing department at 602-258-1743.**
3. **We will submit your claims for you. Please be aware that all balances owed are patient responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.
4. If your coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. A notice stating you have five (5) days to pay your account in full will be mailed to accounts over 60 days past due. Balances that remain unpaid may be referred to a collection agency. In the event we find it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance.

I have read and understand the financial policy of Arizona Endoscopy Center and agree to abide by its guidelines. I authorize the release of any medical or other information acquired in the course of my treatment to my insurance company. I authorize all insurance payments to be made directly to Arizona Endoscopy Center for all medical care rendered. I understand that I am responsible for any and all balances owing regardless of insurance.

_____ _____

Signature of Patient or Responsible Party Date

Patient Label

ARIZONA ENDOSCOPY CENTER
1410 EAST MCDOWELL ROAD
PHOENIX, AZ 85006

The State of Arizona and Medicare regulations require that we ask the following questions so we can carry out your wishes. Do you have a Living Will, assigned Medical Power of Attorney or have you designated a "surrogate" to act on your behalf?

PLEASE COMPLETE THE FOLLOWING INFORMATION and SIGN AT THE BOTTOM

I have a Living Will YES / NO (please circle yes or no)

I have a Medical Power of Attorney YES / NO (please circle yes or no)

I have a designated "surrogate" agent YES / NO (please circle yes or no)

If you have any of the above documents please bring a copy of them with you on the day of your procedure.

I did bring a copy of the above mentioned documents with me today:

YES / NO (please circle yes or no)

I do not have any of the above mentioned documents but would like information about Living Wills, Medical Power of Attorneys and or "Surrogate" agent:

YES / NO (please circle yes or no)

Documents provided as requested YES / NO / N/A

Patient Name (printed please)

_____ _____

Patient Signature or responsible adult's signature Witness Signature

_____

Date

The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

Arizona Endoscopy Center
1410 East McDowell Road
Phoenix, AZ 85006
(602) 258-1743 BILLING DEPT.
(602) 716-9655 MAIN LINE
(602) 716-9655 FAX

EXPLANATION OF YOUR BILL

The total cost for your medical services is comprised of three or possibly four fees. The Endoscopy Center's fee, the Physician's fee, Anesthesia Provider (if applicable), and if biopsies are taken, the Pathologist's fee. Each fee is billed separately by the provider of the service.

- The Endoscopy Center's bill is separate from the Physician's fee.
- Arizona Endoscopy Center's fee covers the cost of providing the technicians, nurses, equipment, and supplies involved in the performance of your procedure. **If you have any questions regarding Arizona Endoscopy Center fees please contact our billing department at 602-258-1743.**
- If there are biopsies taken during your procedure, you will be billed by the pathologist reviewing the tissue (if you have any questions regarding your pathology bill from Arizona Digestive Health Lab, please call 602-264-9100 Ext. 309).
- If Anesthesia Services are required during your procedure, there will be a separate fee for Anesthesia Services. If you have any questions regarding Anesthesia Services fees, please contact Arizona Endoscopy Center Sedation billing office at 1-866-809-1220.
- The Physicians of Gastrointestinal Associates, Dr. Paul Berggreen, Dr. Joseph David, Dr. Brenda Dennert, and Dr. Barbara MacCollum, Advanced Gastroenterology of Arizona, Dr. Darrell Wadas, Dr. Vincent Honan, Dr. Richard Shaughnessy, Dr. Douglas Schwartz, and AmSurg own Arizona Endoscopy Center.
- Your co payment is expected at the time of service. If you have a deductible and/or coinsurance, Arizona Endoscopy Center will be expecting the patient and/or responsible party to leave a debit and/or credit card # on file for all estimated balances. Any questions please contact billing department at 602-258-1743. We accept cash, check, money order, Visa or Mastercard, Amex, Discover, Diners Club, American Express Travelers Check.

SIGNATURE _____ DATE _____

Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy	
Allergies: ☐ Yes ☐ No known allergies	

Label Here

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop Taking after Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop Taking after Discharge

Signature of person filling out form _____ **Date:** _____

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop Taking after Discharge

Signature of Patient/Responsible Person: _____ Date: _____

Nurse Signature: _____ Date: _____

Physician Signature: _____ Date: _____

ARIZONA ENDOSCOPY CENTER
NOTICE OF PRIVACY PRACTICES

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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below.
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy or your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Center Leader

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement
_____ Date: _____

Version 3.0

Effective Date: _____, 2013

FOR SPANISH SEE THE REVERSE SIDE