Island Endoscopy Center, LLC

1175 MONTAUK HIGHWAY SUITE 1
WEST ISLIP, NY 11795
PHONE# (631) 376-0001

PATIENT INFORMATION

Name: _____ _____ _____ SS#: _____
Last First M

Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ Work: _____ Cell: _____

Birth Date: _____ Age: _____ Sex: ____ Marital Status: S ☐ M ☐ W ☐ D ☐

Emergency Contact Person: _____

Patient's Employer: _____ Occupation: _____

Employers Address: _____ _____ _____ _____
Street City State Zip

PLEASE BE SURE TO BRING YOUR INSURANCE CARD TO THE CENTER THE DAY OF YOUR PROCEDURE

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder: _____ DOB of Policy Holder: _____

Social Security # of Policy Holder: _____

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Island Endoscopy Center, LLC for any services furnished to me by that third party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

In the event my insurance company pays me directly, I will forward payment immediately to Island Endoscopy Center, LLC along with the explanation of benefits from my insurance company. If my insurance company fails to make payment for my services, I agree to be financially responsible.

I authorize any holder of any medical or other information about me to release to the Social Security Administration and Health Care Administration or its intermediaries or carriers, information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 112.86 of the Social Security Act and 31 U.S.C. 3801-3912. provides penalties for withholding this information).

Signature: _____ Date: _____

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Privacy Officer: Rajkumar Mariwalla, M.D.

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our *privacy* practices. You *have* the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing *service),* sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is
involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of *our* staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' health care operations activities (to the extent permitted under HIPM)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health *oversight* activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information
Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the· Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access-is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the, information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period wilt be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Right to a Submission and Investigation of Grievances. You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

Physician Financial Interest and Ownership. The Center is owned by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

Changes To This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Island Endoscopy Center, LLC

1175 MONTAUK HIGHWAY SUITE 1
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PATIENT ACKNOWLEDGEMENT

I acknowledge that I have scheduled a procedure at ISLAND ENDOSCOPY CENTER, LLC. I have been given a written copy of the instructions. The instructions include details of my responsibilities as a patient in the Endoscopy Center. I have been made aware of the Legal Ownership of the Center, Billing Practices, Patient's Bill of Rights, Health Care proxy and Privacy Practice. I have been informed that I must bring someone with me for my procedure. I will not be able to drive home. I understand if I do not bring an escort that can drive I will not be able to have the procedure.

I know that if I have any further questions I may call the Endoscopy Center during the hours of 8-4 Monday - Friday.

_____ _____
Date of Procedure Date of receiving Notice

_____ _____
Name of Patient Date of Birth

_____ _____
Day Time Phone # Evening Phone #

_____ _____ _____
Race Ethnicity Last four of SS#

_____ _____
Signature of Patient Surgeon

_____
Primary Insurance Carrier

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Financial Policy

Thank you for choosing our Surgery Center for your procedure. Our staff works very hard to make sure your paperwork is filed accurately and promptly. Thank you in advance for your assistance and patience during this process.

Island Endoscopy Center, LLC is a new Article 28 Ambulatory Surgery Center. Since we are a new facility we are in network with a few carriers. As a patient at the Surgery Center your insurance carrier may receive several bills for services provided. They can include a physician charge, a charge for anesthesia, a pathology charge and a facility charge.

We are aggressively negotiating contracts with all the major insurance carriers for the Surgery Center as well as the anesthesia team.

Your benefits will be verified prior to your procedure and we will obtain your pre approval. We will try and negotiate an acceptable payment from them on your behalf. Based on the terms agreed to during an out-of-network arrangement, an insurance company may oblige a provider to balance bill the patients.

Island Endoscopy Center will accept the-negotiated rate that may have been arranged with your carrier, as payment in full. We will only bill you the in-network co-payment or deductible if applicable.

Please understand that insurance reimbursement can be a long and difficult process for our facility. In fact, insurance companies will routinely stall, deny and reduce payment. You can assist us by giving us the correct insurance information. If your policy or contract has changed please notify us immediately.

Our facility, as a convenience and a service to you, will absorb all costs incurred for billing.

If you do not have insurance please call our facility as we will be happy to negotiate a fee with you.

If you have a financial hardship please feel free to call us and discuss your situation.

We accept cash, check or a credit card for your in-network co-payment.
If you have questions or concerns, please do not hesitate to call the facility.

ISLAND ENDOSCOPY CENTER, LLC

1175 Montauk Highway, Suite 1

West Islip, NY 11795

T 631-376-0001

PATIENT ESCORT POLICY

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

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

Thank you for your cooperation.

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Patient Authorization Form for an Insurance Appeal

Date: _____

Patient/Member Name: _____

Patient #: _____ **DOB:** _____

I hereby authorize Island Endoscopy Center, LLC to appeal my claim with _____ on my behalf, as my Designated Representative. As part of the appeal, I hereby authorize my carrier to communicate with Island Endoscopy Center, LLC in all aspects of the appeal. I understand that these communications may contain the following, all medical and financial information about my treatment relating to my examination.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian

_____
Signature of Witness

_____ _____
Name of Witness Title

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ISLAND ENDOSCOPY CENTER, LLC may use and disclose protected health information (pm) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Island Endoscopy Center, LLC's Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent, Island Endoscopy Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Island Endoscopy Center, LLC at 1175 Montauk Highway Suite 1, West Islip, NY 11795.

With my consent, Island Endoscopy Center, LLC may call home, or other designated location, and leave a message on voice mail, answering machine, or in person in reference to any items that assists the Center in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including pathology results among others.

With my consent, Island Endoscopy Center, LLC may mail to my home or other designated location any items, that assist the Center in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request Island Endoscopy Center, LLC to restrict how it uses or discloses my pm carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Island Endoscopy Center, LLC's use and disclosure of my PHI to carry out TPO,

I may revoke my consent in writing except to the extent that the Center has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Island Endoscopy Center, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient Date

_____

Print Name of Patient or Legal Guardian

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PATIENT INFORMATION SHEET

I was instructed not to eat, drink or take medications (unless specified by my physician) after MIDNIGHT last night and I have followed these 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.

I agree that the Endoscopy Center is not responsible for any valuables I elected to bring with me.

Do we have permission to speak with the person accompanying you regarding your condition? Yes No

Name of person driving you home today:

Waiting Please call at: ( ) _____

SOCIAL SUPPORT SYSTEM
I live alone I live with family or significant other Assisted Living or Nursing Home

_____ _____ _____
Signature of Patient Interviewed By Date

Medication Reconciliation Assessment History Form

Patient Name: _____ Date of Birth: _____ Visit Date: _____

ALLERGIES (To be completed by Patient)		
☐ No Known Drug Allergies		Latex: ☐ No ☐ Yes- Reaction: _____
MEDICATIONS	REACTION	IV Contrast: ☐ No ☐ Yes- Reaction: _____
		Food: ☐ No ☐ Yes- Reaction: _____
		Environment: ☐ No ☐ Yes- Reaction: _____
		Other (Please Specify): _____
HEIGHT: _____	WEIGHT: _____ lbs	

List all medications that you are currently taking, including non-prescription, vitamins, and herbal products. (No Attachments Please)

☐ No Medications

To be completed by Patient					To be completed by Physician	
Medications	**Dose**	**Route** (PO, SC, IV, etc.)	**Frequency**	**Last Dose Taken** (Complete on day of procedure)	**Action**	**Comments**
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	
					☐ Resume ☐ Discontinue	

Completed By: ☐ Patient/Family Member ☐ Physician Office Records ☐ Patient Medication Bottles/List ☐ Facility Medication Record ☐ Pharmacy _____ ☐ Other _____

NEW AND MODIFIED MEDICATIONS (To be completed by Physician)				
Medication Name	**Dose**	**Route**	**Frequency**	**Reason**

ALL new medication orders are to be written on prescription

Date	**Signature of Nurse Obtaining Medication History:**	**Date**	**Signature of Discharging Physician:**

Patient Label