DIGESTIVE HEALTH ENDOSCOPY CENTER

3202 Boone Trail, Fayetteville, NC 28306 | www.digestivehealthendo.com | (910) 323-2477

THIS HAS BEEN PROVIDED FOR YOUR REVIEW.
UPON ARRIVAL AT DIGESTIVE HEALTH ENDOSCOPY CENTER, YOU WILL BE ASKED TO SIGN AN ELECTRONIC VERSION OF THIS FORM

BUSINESS OFFICE FORMS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
TO CAPE FEAR CENTER FOR DIGESTIVE DISEASES, PA

By signing this authorization, I authorize Digestive Health Endoscopy Center, LLC to use and/or disclose certain protected health information (PHI) about me to my physician_____**MD** at Cape Fear Center for Digestive Diseases, PA.

This authorization permits Digestive Health Endoscopy Center, LLC to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): Endoscopy Medical Record.

The information will be used or disclosed for the following purpose: Treatment, Payment (such as reimbursement for care provided by my insurance company, and Health Care Operations, which authorizes all physicians in the Cape Fear Center for Digestive Diseases, PA practice that may be covering during my physician's absence.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from signed date.

I do not have to sign this authorization in order to receive treatment from Digestive Health Endoscopy Center, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Official at:

Privacy Official of Cape Fear Center for Digestive Diseases
Rita Graves
Digestive Health Endoscopy Center
3202 Boone Trail
Fayetteville, NC 28306

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

The intent of this document is to inform you of the financial policy of Digestive Health Endoscopy Center, LLC. We are committed to providing you with the best possible care and service; therefore, your complete understanding of our financial policy as it relates to your financial obligations is essential.

• Payment is due in full at the time of service for all patients who have an insurance policy with which we have no contractual relationship. However, as a courtesy to our patients, we will file your claim with your insurance carrier. Delayed or non-paid claims by your insurance carrier are not the responsibility of Cape Fear Center for Digestive Diseases, P.A. or Digestive Health Endoscopy Center. We accept cash, personal checks, money orders, or credit cards (MasterCard, Visa) as payment for services rendered. Should a credit payment result in an overpayment, the refund will be returned to the same card. **Any credit due that is less than $25.00 will be refunded at the request of the patient. Otherwise, the credit will be applied to future services rendered.**

• A $35.00 returned check fee may be **assessed** to the account for each check returned for insufficient funds, stopped payment, or account closed.

• All deductibles, copayments, and coinsurance are due at the time of service for any patient who has an insurance policy with which we have a contractual relationship. Any service that carrier deems is a non-covered service is the responsibility of the patient and will be payable in full within 30 days after receipt of your billing statement.

• Any past due balances may be subject to additional collection fees, and we reserve the right to turn any patient over to collections if the account is in default of the payment obligation or compliance with this policy.

• Any procedure scheduled by your physician must be canceled with 5 days prior to your appointment. A charge of $100 will be applied to your account within 10 days after the missed procedure. Multiple cancellations or missed appointments without prior notice may result in release from the practice by the physician.

• Administrative charges may be assessed for furnishing copies of your medical records to other physicians, insurance carriers, attorneys or entities providing appropriately signed and legal release. If we are asked to participate in a deposition or to produce, with proper authorization, medical records for your insurance company or attorney, administrative charges may be assessed.

• It is the policy of Digestive Health Endoscopy Center, LLC not to discuss a patient's account information or medical record with anyone other than the patient, unless the patient gives prior written consent.

I agree to forever hold harmless Digestive Health Endoscopy Center, LLC their physicians and staff, for refusal to render further services in the event I do not honor this financial agreement. I understand that for any service I do not pay in full at the time service is rendered, I assign benefits for that claim to Digestive Health Endoscopy Center, LLC. Having read and fully understanding the above information, I authorize Digestive Health Endoscopy Center, LLC to submit appropriate information to my insurance company for processing of my claim.

PATIENT RIGHTS

Digestive Health Endoscopy Center strives to provide excellent care and service. As a patient you have the right to:

1. Become informed of rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information if patient should desire.
2. Be treated with dignity and to be free from all forms of abuse or harassment. Receive considerate and respectful care provided in a safe environment.
3. Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
4. Exercise these rights without regard to age, race, disability, sex or cultural, economic, education, or religious background or the source of payment for care.
5. To communicate with our healthcare professionals in the language or manner you primarily use. Our facility will make reasonable attempt to provide this service.
6. Know the name of the physician and professional staff who have primary responsibility for coordinating your care and the name and professional relationships of other physicians and non-physicians who will participate in care.
7. Receive information regarding illness, course of treatment and prospects for recovery in terms that you can understand.
8. Receive as much information about any proposed treatment or procedure as needed in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
9. Be actively involved in decision making process regarding diagnosis, evaluation, treatment and prognosis of your medical care as permitted by law, this includes the right to request and/or refuse treatment.
10. Know that the Endoscopy Center is limited to elective endoscopy and does not perform high-risk endoscopic procedures. Therefore, the Clinic or Endoscopy Center will **request you to excuse our company from honoring** your advance directives while at our facilities. In the event of an emergency, the patient will be stabilized and transferred to the hospital as soon as possible.
11. Change physicians or professional staff if desired, either within the practice (upon approval) or another health care professional of your choice.
12. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual involved in your healthcare.
13. Confidential treatment of all communications and records pertaining to your care and visit at the Clinic or Endoscopy Center. Your written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care, except when said release is required by law.
14. Full disclosure of the privacy policy.
15. Access information contained in your medical records within a reasonable time frame in accordance with state/ federal laws and regulations.
16. Reasonable responses to any reasonable requests made for service.
17. Leave the Clinic or Endoscopy Center even against the advice of the attending physician.
18. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
19. Be advised if Clinic/Endoscopy Center proposes to engage in or perform human experimentation affecting the care your treatment. You have the right to refuse to participate in such research projects or clinical trials.
20. Be informed by the attending physician or designee of the continuing health care requirements following discharge, to include provisions for after hours and emergency care.
21. Obtain information before scheduled procedure about payment requirements, regardless of source of payment.
22. Examine and receive an explanation of the bill, including an itemized statement, within 30 days of treatment regardless of source of payment.

23. Request in advance of treatment whether the facility accepts Medicare assignment rates (if eligible for Medicare).
24. Have all patient's rights apply to the legal guardian who makes medical decisions on your behalf.
25. Receive the appropriate knowledge regarding absence of malpractice insurance.
26. Receive appropriate information regarding provider credentialing.
27. Be advised of the Clinic/Endoscopy Center's grievance process. Should you wish to communicate a compliment, concern or complaint regarding the quality of care that is received, you may complete and return the Patient Satisfaction Survey for Digestive Health Endoscopy Center provided to you at discharge. If you like to speak with someone contact **the facility Administrator, Nurse Manager, or Medical Director at 910 323-2477 Monday through Thursday from 8am to 5pm and on Friday from 8am until 1pm.**

    You may also contact North Carolina Department of Health and Human Services at:

    North Carolina Department of Health and Human Services
    Division of Health Service Regulation - Complaint Intake Unit
    2711 Mail Service Center
    Raleigh, North Carolina 27699
    Phone: 1-800-624-3004 or visit www.ncdhhs.gov
    Also visit www.cms.gov/center/ombudsman.asp

A list of these Patient's Rights is posted within the Clinic/Endoscopy Center so that such rights may be read by all patients. All Physicians, Clinic/Endoscopy Center personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patient's rights.

PATIENT RESPONSIBILITES

The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be present to the patient in the spirit of mutual trust and respect:

1. Provide accurate and complete information about present complaint, past illnesses, hospitalizations, any medications including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters related to your health status.
2. Make it known whether course of treatment and what is expected of the patient is clearly understood.
3. Follow the treatment plan established by the physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. Provide a mature and responsible adult to transport the patient home from the Endoscopy Center and to be available for the patient for a 24-hour period as required by the physician.
5. Keep appointments and notify the Clinic/Endoscopy Center as soon as possible if unable to keep an appointment.
6. Accept responsibility for any actions resulting from the refusal to follow treatment or physician's orders.
7. Inform the physician about any Living Will, Medical Power or Attorney, or other Directive that could affect the patients care.
8. Accept and ensure that the financial obligations of care are fulfilled as promptly as possible including charges not covered by insurance.
9. Follow Clinic/Endoscopy Center rules and regulations.
10. Be considerate of the rights of other patients and Endoscopy Center personnel.
11. Be respectful of personal property and that of other people in the Endoscopy Center.

I acknowledge the receipt and opportunity to review the Patient's Rights and Responsibilities and information regarding Advanced Directive prior to my procedure.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Written Acknowledgement Form

I,_____**,** hereby acknowledge that Digestive Health Endoscopy Center has given me the opportunity to read and receive a copy of a detailed Notice of their Privacy Practices.

OWNERSHIP STATEMENT

The physicians of Cape Fear Center for Digestive Diseases have a financial interest and ownership in the Digestive Health Endoscopy Center, LLC.

ADVANCE DIRECTIVES

1. Do you have an Advance Directive or Do Not Resuscitate Order (DNR):_____

2. I will supply a copy of my Advance Directive in case of hospital transfer: _____

3. I have read the above and understand **that I excuse** Digestive Health Endoscopy Center from honoring my Advance Directives._____

4. I understand, in the event of an accidental needle stick, I will be required to have blood drawn for testing._____

_____ _____

Signature of Patient **Witness**