Center for Endoscopy

PATIENT INFORMATION

Name: ____
First Middle Initial Last

Address: ____ ZIP: ______________

Other Address: ____

Social Security Number: ________-________-__________ Date of Birth: ______________ **Sex**: [ ] Female [ ] Male

Home Phone: (______) ______________ Other Phone: (______) ______________

Email Address: ______________________________

Marital Status: [ ] Single [ ] Married [ ] Widow [ ] Divorced/Separated

Race: [ ] White [ ] African American [ ] Hispanic [ ] Asian [ ] American Indian/ Native Alaskan [ ] Native Hawaiian/ Pacific Islander [ ] Other

Ethnicity: [ ] Hispanic/ Latino [ ] Non Hispanic/ Latino [ ] Other

Primary Care Physician: ____

Physician who should receive a copy of your procedure report: ______________________________

INSURANCE INFORMATION MUST BE FILLED OUT

Primary Insurance: ______________________________ ID #______________________

Name of Insured if other than self: ____

Date of Birth: ______/______/__________ Social Security Number: __________-________-____________

INSURANCE INFORMATION MUST BE FILLED OUT

Secondary Insurance: ______________________________ ID #______________________

Name of Insured if other than self: ____

Date of Birth: ______/______/__________ Social Security Number: __________-________-____________

Advance Directive

Have you executed an advanced directive? Yes No

You will be accepted for care whether or not you have an advance directive. However, should you become Incapable of making medical decisions during your admission and you do not have an advance directive; The Center is required to find someone (a proxy) to make decisions for you.

I appoint ______________________________________ to make medical decisions if I become Incapable of doing so.

Relationship: ______________________________ Phone: ______________________

Signature: **X**______________________________ Date: ______________________

Restriction of Protected Health Information

In accordance with the Center for Endoscopy's Privacy Practices and to protect the confidentiality of my protected Health information, I hereby direct that disclosure of my protected health information be restricted. Specifically, no documentation of any information related to my stay or treatment, management, or quality assurance purposes, is to be disclosed under any circumstances, redacted or otherwise, to anyone not affiliated with the Center for Endoscopy, for any purpose other than payment, licensure/accreditation requirements, continuation of care, referring or primary care physician without my express written consent or the express written consent of my authorized representative. I understand that this Directive in no way limits my right to access any and all records related to my own medical care and treatment in the health system. I may receive a copy of the facility's privacy practices at any time. The facility's Privacy Practices are also posted in the lobby and on our website.

Signature: **X**______________________________ Date: ______________________

Center for Endoscopy

BENEFIT RELEASE & FINANCIAL ASSIGNMENT

AUTHORIZATION AND RELEASE

- I certify that the information supplied by me for applying for payment is correct. I authorize Center for Endoscopy to release any information about me needed for this claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefit payable for issued directly to Center for the amount due in my pending claim for services of medical and/or surgical treatment.
- I hereby authorize Center for Endoscopy to release to my representative, my attorney, other treating physician and my insurance company any information, including diagnosis and records for any treatment or examination rendered to me.
- I understand that if a check is returned, I will pay the Center the standard charges for a return check fee of $25.
- I understand that I am responsible for all fees related to my care and treatment and if my account is not paid in a timely manner on a monthly basis, my account may be turned over to a collection agency where I agree to pay all collection costs.
- If uninsured I understand that financial arrangements must be made with the Center for Endoscopy Administrator or her/his designee prior to the procedure(s).
- I authorize and request the release of medical records to and from the Center for Endoscopy and my primary care physician and/or referring physician for the purpose of continued medical treatment, payment, insurance, or legal purposes.
- I authorize and voluntarily consent to disclose all information or medical records of my health care at the Center for Endoscopy to my primary care and/or referring physician.
- I understand that this consent can be revoked by me in writing at any time except to the extent this action has already occurred.

I have read, understand, and agree to the above Authorization and Release:

Signature: **X**______________________________________ Date: _______________

FINANCIAL ASSIGNMENT AND AGREEMENT

- Please remember that insurance is considered a method of reimbursement for fees. My authorization above assigns payment directly to the Center for Endoscopy. This is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. *It is my responsibility to pay any deductible amount, co-insurance, co-pay as required by my insurance company.*
- I understand that my insurance policy is a contract between my insurance company and me. The Center is not a party to my contract and my insurance company. *I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay and fails to do so.*
- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
- This agreement will remain in effect until revoked by me in writing. I hereby authorize to release all information necessary to secure the payment. A photocopy of this assignment is to be considered as valid as an original.
- I have been notified that Medicare may deny payment for any services that it does not deem "reasonable and necessary" under program standards, if Medicare denies payment I agree to be personally and fully responsible for payment.

I have read, understand, and agree to the above Financial Assignment:

Signature: **X**______________________________________ Date: _______________

If this document was signed by someone other than the patient, please state the reason the patient was unable to sign:

____

Title/Relationship: ____________________________

PATIENT LABEL

Center for Endoscopy ABUSE HOTLINE 1-800-962-2873

Medicare Ombudsman: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

PATIENT'S RIGHTS:

This facility and medical staff have adopted the following list of patient rights. This list shall include, but not be limited to, the patient's rights to:

- A patient shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by their health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse treatment, except and otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and upon request, to have charges explained.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of their rights, as stated in Florida law, through the grievance procedure of the facility which served them and to the appropriate state licensing agency.
- A patient has the right to refuse to participate in experimental research.
- A patient has the right to file a grievance through the Center's formal grievance process.
- A patient has the right to have an advance directive concerning treatment to the extent permitted by law.

PATIENT'S RESPONSIBILITIES:

The care a patient receives depends particularly on the patient himself/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well.

- A patient is responsible for providing to the health care provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- A patient is responsible for reporting unexpected changes in their condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether they comprehend a contemplated course of action and what is expected of them.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and when they are unable to do so for any reason, for notifying the health care provider or facility.
- A patient is responsible for their actions if they refuse treatment or for not following the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.
- A patient is responsible for following health care and facility rules and regulations affecting patient care and conduct.

______________________________ ____________________

Signature of Patient or Responsible Party Date

PHYSICIAN OWNED FACILITY

The physicians listed below are on staff at the Center for Endoscopy providing medical services and are in fact the owners of the facility and/or anesthesia and pathology companies. You may choose to have your surgery in a facility not owned by the physicians listed. By signing below, you acknowledge that you have been given this option and choose to have your surgery at The Center for Endoscopy.

Charles Loewe, MD; Arun Khazanchi, MD; Tonantzin Matheus, MD;
John Southerland, MD; Ronald Andari, MD; Avantika Mishra, MD

ADVANCED DIRECTIVES

The Center for Endoscopy does not honor Advanced Directives. Unexpected complications due to anesthesia and/or surgery are not natural causes and therefore will be treated. This means 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. At the acute hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. The admitting facility is not affiliated or in partnership with the Center for Endoscopy.

BILLING DISCLOSURE

The Center for Endoscopy will verify your insurance coverage benefits as a courtesy. However, it is the patient's responsibility to understand the coverage of their insurance plan and what it covers. There are 4 separate billing components that you may receive charges/bills from which may include: The Facility, your procedure physician, pathology and anesthesia. There may be an entity that is not in network with your insurance plan. You may contact each separate entity listed below to verify coverage.

Facility – Center for Endoscopy: (941) 552-3480
Physician – Contact your physician's office
Anesthesia – FDHS Anesthesia LLC: (941) 269-0557 or 800-242-5080
Pathology - FDHS Pathology: (941) 757-4820

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS/FACILITY

I understand that my insurance company may send payments for the rendered services to me. I hereby assign to the above-named physicians all surgical, medical insurance, and/or other benefits, if any, otherwise payable to me for their services at the Surgery Center. I agree to endorse the checks over to the facility. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to the above-named facility from the obligor of said benefits. Further, I hereby assign and convey to the above named physicians/facility, unless charges for their services have been paid, so much of any cause of action or right to recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for the above named physician's services from any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds.

GRIEVANCE PROCEDURE

The Center for Endoscopy values you as a patient. We are dedicated to ensuring your relationship with us is positive one. If we can enhance that relationship in any way, please let us know. Every patient has the right to express complaints about the care and services provided to any staff member. If the patient is not satisfied with the resolution, the complaint is taken to the CEO. A formal grievance form can be obtained from the Receptionist. Patients or the patient's representative may also file a written complaint/grievance with the CEO at:

Center for Endoscopy
3325 Tamiami Trail, Ste. 100
Sarasota, FL 34239
(941) 552-3480

The CEO will be responsible for providing the patient with a written response within fourteen (14) days from the date of receipt of the complaint or grievance. The patient has the right to complain to the following agencies if our facility's response is not satisfactory:

Florida State Department of Health
(850) 245-4339

Medicare Beneficiary Ombudsman
(800) MEDICARE (800) 633-4273
www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the procedure and have decided to have your procedure performed at this center.

X______________________________ ______________________

Signature of Patient or Responsible Party Date

FDHS Anesthesia, LLC & Anesthesia Dynamics, LLC

Providing Professional Anesthesia Services for patients at Center for Endoscopy

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to FDHS Anesthesia, LLC (FDHSA) and Anesthesia Dynamics, LLC (AD) all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between FDHSA/AD and my insurance company. I authorize and direct the insurance company to pay all such benefits to FDHSA/AD. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and FDHSA/AD.

Authorization to Release Claims Information: I hereby authorize FDHSA/AD it employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize FDHSA/AD its employees and agents to act on my behalf in completing claims including any appeal process.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that FDHSA is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

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Signature of Patient/Authorized Guardian Signature **Date**

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Print Patient Name

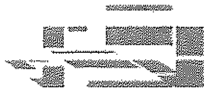
PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at Center for Endoscopy by FDHSA. FDHSA contracts and employees certified registered nurse anesthetists as part of the anesthesia care team.

Anesthesia services will be billed separately from the services of Center for Endoscopy.

For billing questions or concerns, please call: 1-800-242-5080 or 941-269-0557.

In the event that FDHSA/AD is not a participating provider with your insurance plan, FDHSA/AD will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses due to FDHSA/AD but-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.

 CENTER FOR ENDOSCOPY

Authorization to Disclose Information to a Third Party

I, ______________________________, authorize the Center for Endoscopy to release my protected health information to the person(s) listed below under the circumstances indicated:

(Please initial the information you wish to be shared)

________________________________	________________________________
Name of Authorized Person	**Relationship to Patient**
SELECT ONE	**SELECT ONE**
_____Only if I become incapacitated	_____ Financial Records Only
_____Only if I am unable to be contacted	_____ Medical Records Only
_____Without limitations	_____ Both Financial and Medical Records

I understand that individuals not listed (including my spouse) may not receive my information without my authorization under the Health Insurance Portability and Accountability Act of 1996, (HIPAA).

____________________________________ ____________________________________

Patient Signature Date

Disclosure will be valid for 1 year

RESPONSIBLE ADULT

My Responsible Adult, driving and/or accompanying me home from my procedure is:

Name:____

Relation:______________________________________

Phone Number: ______________________________