GEORGIA ENDOSCOPY CENTER, LLC
AND
ENDOSCOPY CONSULTANTS, LLC
PATIENT INFORMATION

I request that payment of authorized benefits be made to **GEORGIA ENDOSCOPY CENTER, LLC (GEC)** and/or **ENDOSCOPY CONSULTANTS, LLC (EC).** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **GEC** and/or **EC** and for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I understand that any up front out of pocket costs quoted are an estimate only and that additional procedures, biopsies, tissue removal and anesthesia costs will result in additional personal financial responsibility. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **GEC** and/or **EC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

SIGNATURE ____ **Date** ______________

RELATIONSHIP TO PATIENT __________________________

ALTERNATIVE CONTACT AUTHORIZATION

I ☐ **DO** ☐ **DO NOT** authorize **GEC** and/or **EC** to contact me or leave messages.
Date:______________ Initials:______________

I ☐ **DO** ☐ **DO NOT** authorize **GEC** and/or **EC** to discuss my appointments, medical evaluation, treatment and results to relatives or other persons as indicated:

Authorized person(s)/relationship: ______________________ Initials :______________Date: ______________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **"NOTICE OF PRIVACY PRACTICES"** for my records.

Signature:________________________________Date:__

ADVANCE DIRECTIVES AND PATIENT'S RIGHTS & RESPONSIBILITIES

I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I also acknowledge that I ☐ **DO** ☐ **DO NOT** have such Directives. If I do not have such Directives at this time, but establish them at a later date, I will provide the Center with a copy.

Initials:________ Date:________Instructions/location of directives if not provided at this time: ______________

I acknowledge that I have been provided the Rights and Responsibilities that include the notification of physician ownership, the facility policy on Advance Directives, and how to file a complaint and/or grievance.

Signature:__________________________ Date:______________

Updated 12-23-14

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PATIENT INFORMATION

DATE OF PROCEDURE	TIME	PHYSICIAN	PREVIOUS PATIENT? Yes No	REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN
PROCEDURE				

PLEASE PRINT

PATIENT

Name (Last-First-Middle)	Gender	Social Security No.	Date of Birth	
Address		City	State	Zip Code
Home Phone ( )	Cell Phone ( )	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed		

SPOUSE, GUARDIAN, Or EMERGENCY CONTACT

Spouse or Guardian	Relationship	Date of Birth	Social Security No.	Home Phone ( )	Cell Phone ( )
Address			City	State	Zip Code
Nearest Relative or Friend at Different Address	Relationship	Address		Home Phone ( )	Cell Phone ( )

INSURANCE INFORMATION
(Please provide [redacted] insurance card)

PRIMARY INSURANCE

Name of Insurance Company			Name of Insured		
Insured Social Security Number	Insured Date of Birth	Policy Number	Group Number		
Address (Where to Submit Claim)	City	State	Zip Code	Phone Number ( )	

SECONDARY INSURANCE

Name of Insurance Company			Name of Insured		
Insured Social Security Number	Insured Date of Birth	Policy Number	Group Number		
Address (Where to Submit Claim)	City	State	Zip Code	Phone Number ( )	

(PLEASE SEE PAGE 2 FOR ACKNOWLEDGEMENTS)

GEORGIA ENDOSCOPY CENTER, LLC
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Patient Rights

a. The Center is owned by Eugene H. Hirsh, M.D., Alan M. Fixelle, M.D., Jay A. Cherner, M.D., M. Thomas Riddick, M.D., and Bruce A. Salzberg, M.D., and Tenet Healthcare. All physicians retain privileges at the Center. Patients have the right to choose another facility for their procedure. The patient will be provided a copy of the "Patient Rights and Responsibilities" prior to the procedure.
b. The patient has the right to be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression and be free from all forms of abuse or harassment.
c. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity and with respect to culture, religion and personal values.
d. Patients have the right to a safe and pleasant environment and shall receive assistance in a prompt, courteous, and responsible manner.
e. Patient disclosures and medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. . Patients have the right to access medical records and information.
f. Patients have the right to know the credentials, identity and status of individuals providing services to them and have the right to change providers or facility if they so choose.
g. Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form for providing medical service after all information has been provided and their questions answered.
h. When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized representative or surrogate.
i. Unless participation is medically contraindicated, patients have the right to participate in all informed decisions involving their healthcare.
j. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
k. Patients have the right to refuse participation in experimental and/or research treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
l. Patients have the right to make suggestions or express complaints about the care they have received (or fail to receive) and to submit such to the Center Administrator or Clinical Supervisor so the grievance may be addressed in a timely manner.
m. Patients have the right to be provided with information regarding emergency and after-hours care.
n. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
o. Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
p. Patients have the right to have procedures performed in the most painless way possible.
q. Patients have the right to an interpreter if required. When the need arises, reasonable attempts will be made for health care professionals and other staff to communicate in the language or manner primarily used by the patient.
r. Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
s. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Center and its staff.
t. Patients have the right to have copies of their "Advance Directives" and "Living Wills" in their medical records and to have Center staff honor these wishes to the extent feasible. However, due to the Center's limited capabilities, in the event of an emergency, the patient will be transferred to the nearest hospital. Hospital staff will be informed of the existence of the Advance Directives and such will be provided if the Center has copies.
u. Patients will be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payment.
v. Patients have the right to exercise his/her rights without being subject to discrimination or reprisal.
w. If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
x. Patient has a right to receive professional medical services.
y. Patent has the right to apply to court for financial compensation and non-financial damages because of the rights infringement, malpractice, faults of institution, inadequate supervision or control by State, suspending or revoking provider license, changing state medical standards.
z. Patient has the right to access the State medical program.
aa. Patient has the right to receive comprehensive and timely information on resources, payment, risk/benefit or procedure, results of medical investigations, alternatives, results of refusal, diagnosis, prognosis and ongoing treatment, identity and experience of provider.
bb. Patient has the right to express life-saving or palliative care and entitle someone else to make decisions when patient becomes incompetent.
cc. Patient has the right to confidentiality within life and after death except in limited situations.

Update 7-16-14

GEORGIA ENDOSCOPY CENTER, LLC
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Patient Responsibilities

a. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products and dietary supplements and any allergies or sensitivities.

b. Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.

c. Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.

d. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.

e. Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Center Administrator.

f. Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.

g. Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.

h. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.

i. Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.

j. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care.

k. Patients are responsible for having a responsible adult transport them from the Center and remain with the patient for twenty-four (24) hours, if required by the Physician.

l. The patient will be provided a copy of the Patient Rights and Responsibilities prior to the procedure.

The patient or family may voice concerns or complaints without having care affected in any way. They may discuss their concerns with their doctor, nurse, or other caregiver. If concerns are not resolved, they should contact the Administrator at **770-821-6800 or 678-399-2050**. If preferred, the patient/caregiver may contact the Complaint Line of the Healthcare Facility Regulation Division of the Georgia Department of Community Health at 404-657-5728 or at 2 Peachtree Street NW, 31st Floor, Atlanta, Georgia, 30303-3142 or their Ombudsman at 800-MEDICARE or www.cms.hhs.gov/center/ombudsman.asp.

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PRE-PROCEDURE ANESTHESIA EVALUATION

DO YOU HAVE OR HAVE YOU HAD:

☐ Yes ☐ No **Any ALLERGIES** to food, chemicals, **medications**, shellfish, **latex**? If yes, specify: ____________________

☐ Yes ☐ No Have you had anything to eat or drink since **midnight**? If yes, what?______________
☐ Yes ☐ No Are you or could you be **pregnant**?
☐ Yes ☐ No Personal or family history of problems with anesthesia? (Including high fever)
☐ Yes ☐ No Difficult intubation?
☐ Yes ☐ No Have you ever experienced excessive drowsiness, respiratory or cardiac problems following sedation? If yes, specify:____________________
☐ Yes ☐ No Breathing difficulty or sleep apnea?
☐ Yes ☐ No Heart disease (including: heart attack, murmur, pacemaker, bypass surgery, mitral valve prolapse, etc.)?
☐ Yes ☐ No Chest pain?
☐ Yes ☐ No An *abnormal EKG (irregular heartbeat, MI)?*
☐ Yes ☐ No Hypertension (high blood pressure)?
☐ Yes ☐ No Elevated cholesterol or lipids?
☐ Yes ☐ No Lung disease (shortness of breath, chronic cough, asthma)?
☐ Yes ☐ No An *abnormal* chest x-ray?
☐ Yes ☐ No Kidney disease? Specify:____________________
☐ Yes ☐ No Liver disease/hepatitis/jaundice? Reflux? Specify:____________________
☐ Yes ☐ No Bleeding or clotting abnormalities? Specify:____________________
☐ Yes ☐ No Diabetes?
☐ Yes ☐ No Thyroid or goiter problems?
☐ Yes ☐ No Epilepsy/seizures? Neurological problems?
☐ Yes ☐ No Back trouble or neck problems? Specify:____________________
☐ Yes ☐ No Advanced rheumatoid arthritis?
☐ Yes ☐ No TMJ syndrome or history of facial fracture?
☐ Yes ☐ No Past/present possible carrier of contagious disease? Specify:____________________
☐ Yes ☐ No Any alcohol use?__________ How much?____________________
☐ Yes ☐ No Do you currently smoke or have you ever smoked? Amount per day:________How long?____________
☐ Yes ☐ No Have you taken medicine or products containing **aspirin or blood thinners** the past 5 days? List:____________________Last taken on ________________
☐ Yes ☐ No Are you currently taking any herbal supplements/medication? List:____________________

Please list all medications that you are **currently** taking. (Attach list if necessary)

Medication	Dosage	Frequency

DO YOU HAVE ANY OF THE FOLLOWING?
☐ Yes ☐ No A. Dentures_________ B. Partial Plate______ C. Bridgework-Permanent______ D. Caps______

ARE YOU WEARING ANY OF THE FOLLOWING?
☐ Yes ☐ No A. Contacts______ B. False Eyelashes______ C. Wig/Hairpiece______ Hearing Aid ______

List any other current medical problems:____________________

List past surgical history:____________________

Pertinent Family History: ____________________

PATIENT SIGNATURE:____________________ DATE ______________

ANESTHESIOLOGIST SIGNATURE:____________________ DATE ______________ TIME ___________