Endoscopy Center

PLEASE READ AND COMPLETE THE ATTACHED PAPERWORK PRIOR TO ARRIVING FOR YOUR PROCEDURE. YOU CAN'T BE TAKEN IN FOR YOUR PROCEDURE UNTIL IT IS FULLY COMPLETED.

Please be advised...

The attached paperwork is required before your procedure can take place; therefore please take the time to complete the entire packet before coming into the office.

If your paperwork is not completed there is a high chance that another patient will be seen ahead of you, regardless of your appointment time.

NOTE: NO UBER, LYFT, TAXI CAB's or MEDICAL TRANSPORTATION ALLOWED unless you are accompanied by a responsible adult which is someone that you personally know. Could be your neighbor, friend, relative, significant other.

If you have any questions, please call our office at: 714-284-0737

AGMG Endoscopy Center

1211 W. La Palma, #301, Anaheim, California 92801
714.284.0737 • Fax 714.284.0720

Dear Patient,

Attached you will find a blank demographic/registration form, your Notice of Patient Privacy and a Medication List. Please fill out the registration form and Medication list completely and bring it with you to your appointment. You will also need to bring your insurance card and GI order sheet. If you wear glasses, please be sure to bring them, as you will be reading and signing a consent form.

Please remember you must have someone to drive you home, as you will be sedated for your procedure, i.e.: Colonoscopy or Endoscopy. Due to limited space in our waiting room *no children are allowed* and we ask that you have your ride either wait in the lobby of the hospital (next door) or leave a phone number that we can call just before you are released.

Be aware that there is a ***possibility*** that you could receive up to 4 different bills for your procedure depending on your insurance if you have any co-pays or deductibles. The statement from AGMG Endoscopy Center is for the facility (place) where you had your procedure; the statement from Associated Gastroenterology Medical Group is for the doctor's time doing the procedure; you could also receive a bill from the lab if you have a biopsy or pathology; and possibly another billing from the anesthesiologist if you receive his/her services.

HMO patients: Please note that many plans have an outpatient facility co-pay; this is different than your office visit co-pay. Please check your policy or call your insurance company prior to your procedure date.

You should plan on being here for approximately 2 to 3 hours from your check-in time.

This is to inform you that Drs. Dennis Riff, Michael DeMicco, Steven Duckor and Peter Winkle have partnered ownership in AGMG Endoscopy Center.

You will receive a phone call prior to your scheduled procedure date to confirm your appointment, verify that you have received your advanced directives and patient rights and responsibilities and answer any questions you may have. **The Endoscopy Center Staff *must* speak with you prior to your appointment date or your procedure will be cancelled and rescheduled. *There will be no exceptions*.**

If you have any questions, please feel free to contact our office at the phone number listed above.

Sincerely,

AGMG Endoscopy Center Staff

6.22.17 cel

AGMG ENDOSCOPY CENTER

PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE

PATIENT'S ACCOUNT #	DATE	DRIVER'S LICENSE (IF NOT CA, LIST STATE)
NAME (LAST, FIRST, M.I.)		HOME TELEPHONE #
ADDRESS		E-MAIL ADDRESS
CITY	STATE ZIP CODE	CELLPHONE

SOCIAL SECURITY NO.	DATE OF BIRTH	MARITAL STATUS SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___
WHO REFERRED YOU?	YOUR EMPLOYER	WORK TELEPHONE #
EMPLOYER ADDRESS	CITY	STATE ZIP CODE
SPOUSE'S NAME	THEIR EMPLOYER	
WHO SHOULD WE CALL IN CASE OF AN EMERGENCY?	RELATIONSHIP	TELEPHONE

PRIMARY INSURANCE INFORMATION ☐ INS. CARD COPY ☐ DRIVER'S LIC. COPY

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE

INSURANCE NAME & ADDRESS		
HMO/IPA:		PCP:
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY

SECONDARY INSURANCE INFORMATION ☐ INS. CARD COPY

PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE NAME & ADDRESS		
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY

I hereby authorize all insurance benefits to be paid directly to AGMG ENDOSCOPY CENTER. I understand that I am responsible for charges as designated by my insurance companies (e.g., deductibles, co-payments). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize AGMG ENDOSCOPY CENTER to release any information to my insurance companies when requested by them.

DATE

SIGNED (Insured or Authorized)

ACMC Endoscopy Center

MEDICATION RECONCILIATION LIST

NAME: _____ DATE: _____

DATE OF BIRTH: _____

ALLERGIES / SENSITIVITIES / REACTIONS: _____

_____

Patient denies any medications ☐ Yes ☐ No Vitamins ☐ Yes ☐ No Herbals ☐ Yes ☐ No
NSAIDS ☐ Yes ☐ No ASA / Blood Thiners ☐ Yes ☐ No Laxatives ☐ Yes ☐ No

Current Patient's Medications List

(Prescription, Over-the-Counter, Herbals, Patches, Inhalers, Eye Drops, Vitamins, Supplements, Topicals)

MEDICATIONS	DOSE	FREQUENCY (WHEN)	ROUTE (HOW)	INDICATION (WHY TAKING MEDICATION?)	TO BE FILLED IN BY NURSES ONLY		
					DATE LAST TAKEN	TO BE COMPLETED FOR DISCHARGE: RESUME	DISCONTINUE

☐ **Stop taking Aspirin, Motrin, Aleve, Ibuprofen, Advil and similar medication for _____ days.**

☐ **Resume Anticoagulant in _____ days.**

FOR NURSING STAFF ONLY — NEW MEDICATIONS				
MEDICATIONS	DOSE	FREQUENCY	ROUTE	INDICATION

Signature of RN obtaining original list: _____ Date/Time: _____

Signature of Anesthesiologist: _____ Date/Time: _____

Signature of Discharge RN: _____ Date/Time: _____

Signature of Physician: _____ Date/Time: _____

REV. 02/20
re-order from C. Denmark 714-655-4868

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

Patient Name:_____ DOB:_____/_____/_____
Month Day Year

Authorized Methods of Communication (✔ Check all that apply)			
❑ *Residence Telephone*	❑ *Work Telephone*	❑ *Written Correspondence*	❑ *Other (Specify)*
Number: ( )	Number: ( )	❑ Mail/Delivery Service	
❑ Leave call back number only; do not leave message	❑ Leave call back number only; do not leave message	❑ Fax: ( )	
❑ Okay to leave detailed message with person	❑ Okay to leave detailed message with operator	❑ E-Mail @ Residence:	
❑ Okay to leave detailed message on answering machine	❑ Okay to leave detailed message on personal voice mail	❑ E-Mail @ Work:	

Patient Signature:_____ Date:_____

Record of Disclosures

Date Of Disclosure	Disclosed to: Name & Address or Contact Number	Description of PHI Disclosed and Purpose of Disclosure (If a copy of the authorization or request is attached, check ❑ below.)	Type of Disclosure *Enter T, P, or O	Person Disclosing	Method of Disclosure **Enter M, P, F, E, or OT
		❑			
		❑			
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		❑			
		❑			
		❑			
		❑			

*T = Treatment, P = Payment, O = Health Care Operations Activities
**M = Mail, P = Telephone, F = Fax, E = E-Mail, OT = Other (and specify mode of delivery)

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HIPAA Notice of Privacy Practices

AGMG Endoscopy Center
1211 W. La Palma Ave. #301
Anaheim, CA 92801
714-284-0737

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request, if the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

Information provided to patient or representative on: _____ Date

☐ In Person ☐ Mailed _____

☐ Fax # _____ ☐ Fax Confirmation

☐ Emailed _____

Staff Initials _____

Endoscopy Center AGMG

1211 West La Palma Ave., Suite 301
Anaheim, CA 92801
(714) 284-0737 • Fax (714) 284-0720

_____
Patient Name **(Print)**

_____
Date of Birth

PATIENTS RIGHTS AND RESPONSIBILITIES

AGMG Endoscopy Center has adopted the following list of Rights and Responsibilities for Patients:

1. Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for your care.
2. Considerate and respectful care.
3. Knowledge of the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians who will see you.
4. Receive information from your physician about your illness, your course of treatment and your prospects for recovery in terms that you can understand.
5. Receive as much information about any proposed treatment or procedure as you may need 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 courses of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out this procedure or treatment.
6. Participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning your medical 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.
8. Confidential treatment of all communications and records pertaining to your care and your stay at the Endoscopy Center. Your written permission shall be obtained before your medical records can be made available to anyone not directly concerned with your care.
9. Reasonable responses to any reasonable requests you may make for service.
10. Leave the Endoscopy Center even against the advice of your physicians.
11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
12. Be advised if the Endoscopy Center/personal physician proposed to engage in or perform human experimentation affecting your care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed by your physician or a delegate of your physician of your continuing health care requirements following your discharge from the Endoscopy Center.
14. Examine and receive an explanation of your bill regardless of source of payment.
15. Know which Endoscopy Center rules and policies apply to your conduct as a patient.
16. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. The patient has the right to be free from all forms of abuse or harassment.
18. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.
19. Patient has the right to change providers if other qualified providers are available.
20. **Disclosure of ownership, AGMG Endoscopy Center physicians have financial interest in this center.**

PATIENTS RESPONSIBILITIES:

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities shall be presented to the patient in the spirit of mutual trust and respect.

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to his/her health, including but not limited to current illnesses such as hepatitis, HIV or other transmittable diseases.
2. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instruction of nurses and other health professionals as they carry out the physician's orders. The patient should express any concerns they have about following the proposed care plan.
4. The patient and family are responsible for the outcomes if they do not follow the care plan.
5. The patient is responsible for keeping appointments and for notifying the Endoscopy Center or physician when he/she is unable to do so.
6. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her orders.
7. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
8. The patient is responsible for following facility policies and procedures.
9. The patient is responsible for being considerate of the rights of other patients and facility personnel.
10. The patient is responsible for being respectful of his/her personal property and that of other persons in the Endoscopy Center.
11. The patient has the responsibility to provide a responsible adult to transport him / her home from the Center and remain with him / her for 24 hours, if required by his / her physician.
12. The patient has the responsibility to inform his / her provider about any living will, medical power of attorney, or other directive that could affect his / her care.

ADVANCE DIRECTIVES:

The rights of patient(s) also include the right to an advance directive. An "Advance Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the official State advance directive forms, visit
http://www.calhealth.org/Download/AdvanceDirective_English.pdf or
http://www.calhealth.org/Download/AdvanceDirective_Spanish.pdf

OUR AGMG ENDOSCOPY CENTER'S ADVANCE DIRECTIVE POLICY:

The majority of procedures performed at our Center are considered to be of minimal risk. Of course, no procedure is without risk. You and your Gastroenterologist will have discussed the specifics of your procedure and the risks associated with your procedure, the expected recovery and the care after your procedure.

It is the policy of our Center, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Center, the personnel at the Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care 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.

PATIENT CONCERNS AND/OR GRIEVANCES:

Persons who have a concern or grievance regarding AGMG Endoscopy Center, including but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the Administrator verbally or write a statement to:

Administrator
1211 West La Palma Avenue Suite 301
Anaheim California 92801

You may also contact the following: AGMG Endoscopy Center is Medicare Certified and is Accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Any complaints regarding services provided at AGMG Endoscopy Center can be directed in writing or by telephone to:

AAAHC
Accreditation Association For Ambulatory Health Care, Inc.
5250 Old Orchard Road, Ste 200
Skokie, IL 60077-9938
847-853-6060

District Administrator for the California Department of Public Health
681 South Parker St. Suite 200
Orange, CA 92868
714-567-2906

Medicare patients should visit the website below to understand their rights and protections. Office of the Medicare Beneficiary Ombudsman at www.cms.hhs.gov/ombudsman/resources.asp
800-633-4227

I have received information on patient rights, patient responsibilities, physician disclosure, advance directive policy and grievance policy at least one day in advance of my procedure, unless, I was referred to the AGMG Endoscopy Center for procedure on that same date on emergency basis.

_____
Patient Name **(Print)**

_____
Patient Signature

_____
Date