Central Arizona Endoscopy

Medication Sheet

Please fill out this sheet indicating your medication, dosages and frequency and bring it with you on the day of your procedure.
If you are taking an anticoagulant or blood thinner such as aspirin, Coumadin (warfarin), apixaban (Eliquis), rivaroxaban (Xarelto), dabigatran (Pradaxa), etc., please indicate the day you stopped if instructed to do so by your physician.

MEDICATION	DOSAGE	FREQUENCY	LAST DOSE

ALLERGIES	REACTION

Admit Nurse Review _____ RR Nurse Review _____

Physician Review _____ Continue Present Medication ☐

Medication Changes _____

_____

N/A ☐

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology --- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention.

Please be aware that some of the physicians performing procedures here have a direct financial ownership interest in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The fee that we charge for our services covers the non-professional component of your procedure also known as the "technical" or "facility" fee which includes the cost of operating this facility including equipment, staff, rent, supplies, etc. You will also receive a separate bill from the physician's office for their professional services, and possibly the laboratory for any pathology services. The facility, laboratory and physicians' professional office are all separate legal entities providing separate and distinct services.
2. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process as long as we have the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.
3. We expect all known co-payments and deductibles, except for those due under Medicare/Medicaid or other federal healthcare programs, to be paid at the time of service or as required by the contract between the patient, the insurer and our center. We reserve the right to collect co-pays, deductibles and coinsurance upon notification by the insurer.
4. Some insurers require pre-certification, preauthorization or a written referral. It is the patient's responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. If your insurance denies the claim, you may be ultimately responsible for the balance.
5. If you have any questions related to the balance, please contact our Billing Office to discuss your account. Non-payment will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

☐ Patient has been given a Patient's Rights and Responsibilities brochure, Disclosure of Financial interests or ownership in the facility and notification of the facility's policy on advanced directives prior to the day of the procedure.

Authorization to release information: I hereby authorize Central Arizona Endoscopy, LLC to release any and all information necessary for the billing and processing of the account for services rendered.

Assignment of Insurance Benefits: I hereby authorize payment to Central Arizona, LLC insurance benefits, otherwise payable to me, for this service. Payment to Central Arizona, LLC shall not exceed the balance due for services rendered.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility and that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the Center.

Patient's Name (printed): _____ **Date:** _____

Patient's Signature: _____

Center Representative: _____

Central Arizona Endoscopy
Red Mountain Professional Plaza
2158 N. Gilbert Road, Building 1, Suite 103
Mesa, AZ 85203
☎ 480.751.3002 | 480.751.3003
www.centralazendo.com

Central Arizona Endoscopy, LLC
Patient Consent and Acknowledgement of Privacy Practices
For Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

<Patient name>_____, hereby states that by signing this Consent, I agree and acknowledge the following:

1. Notice of Privacy Practices ("Privacy Notice") for Central Arizona Endoscopy, LLC (the "Center") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") the Center. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The Center reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Center:

    a. A postcard mailed to me at the address provided by me; and/or
    b. Telephoning my home and leaving a message on my answering machine.

3. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Center will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Signature Patient or Legal Representative Date

_____ _____
Signature Witness Date

FOR USE BY THE CENTER ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____
_____
_____
_____

Signature of Center representative:_____

Printed Name of Center representative:_____

Date:_____

PATIENT LABEL

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NOTICE OF PRIVACY PRACTICES

The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal and receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor. The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse. The patient has the right to exercise his/her rights without being subjected to discrimination or reprisal.

- 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.
- If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

Respect

- Patients are treated with respect, consideration and dignity for both property and person.
- The organization respects the patient's cultural and personal values, beliefs, and preferences.
- The organization respects the patient's right to pain management.
- The patient's rights will be protected and respected during research, investigation and clinical trials.

Communication

- The organization respects the patient's right to and need for effective communication.

Dignity/Privacy

- Patients are provided appropriate respect for privacy and confidentiality including all information and records pertaining to their treatment.
- The organization treats the patient in a dignified and respectful manner that supports his/her dignity.
- Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

Consideration and Safety

- Receive care in a safe setting.
- Be free from all forms of abuse and harassment.
- Patient's right to refuse to participate in experimental research or refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her actions.
- The patient may refuse care, treatment, or services, in accordance with law and regulation.
- The patient has the right to actively participate in decisions about his/her care.
- Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.
- Patients are informed of their right to change their provider if other qualified providers are available.
- Patients are given the opportunity to participate in decisions involving their care, except when such participation is contraindicated for medical reasons.
- The organization involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.

- The organization honors the patient's right to give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his or her care.

Confidentiality

- Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law or third party payment contract.

Information

- The organization allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis before the treatment or procedure tailored to the patient's age, language, and ability to understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- The organization provides interpreting and translation services, as necessary.
- The organization communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.
- Patient conduct, responsibilities and participation.
- Disclose physician financial interests or ownership in the Center.
- Services available at the organization.
- Provisions for after-hours and emergency care.
- Fees for services, eligibility for third party reimbursement and, when applicable, the availability of free or reduced cost care and receive an itemized copy of his/her account statement, upon request.
- Payment policies.
- Advance directives, as required by state or federal law and regulations and if requested, official State advance directive forms.
- Document in a prominent part of the patient's current medical record, whether or not the individual had executed an advance directive.
- The credentials of health care professionals.
- The patient will be informed of his/her rights prior to the procedure in a manner in which the patient or the patient's representative understands. The center must protect and promote the exercise of such rights.
- Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
- Patients are provided with appropriate information regarding the absence of malpractice insurance coverage, if applicable.
- The organization informs the patient or surrogate decision maker- about unanticipated outcomes of care, treatment, or services that relate to sentinel events considered by The Joint Commission.
- Representation of accreditation to the public must accurately reflect the accredited entity.
- Patients may access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this Title.
- Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision. A patient has the right to give or withhold informed consent

- Patients are informed about procedures for expressing suggestions, complaints and grievances regarding treatment or care that is (or fails to be) furnished, including those required by state and federal regulations
  Complaints should be registered by contacting the center and/or patient advocate through the State Department of Health or Medicare. The center will respond in writing with notice of how the grievance has been addressed within 30 days.

Administrator: Emina Arcan
2158 N. Gilbert Road
Building 1 Suite 103
Mesa, AZ. 85203
480-751-3002
Fax- 480-751-3003
www.centralazendo.com

Medicare Beneficiary Ombudsman
1-800-MEDICARE
1-800-633-4227
http://www.medicare.govlc laims-and-a ppealslmedicare-rights /get-help/ombudsman.html

Arizona Department of Health Services
150 North 18th Avenue
Phoenix, Arizona 85007
(602) 542-1025
Fax: (602) 542-0883
http://azdhs.gov/licensing/medical-facilities/index.php

For concerns about patient safety and quality of care that you feel have not been addressed appropriately by the center Administrator, you can also contact:

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
E-mail: info@aaahc.org
Tel: 847-853-6060
Fax: 847-853-9028

The patient has the responsibility to do the following:

- *The patient is encouraged to ask any and all questions of the physician and staff in order that he/she may have a full knowledge of the procedure and aftercare.*
- *Follow the treatment plan prescribed by his/her provider and participate in his/her care.*
- *Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.*
- *Provide the organization with information about their expectations of and satisfaction with the organization.*
- *Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.*

- *Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.*

- *Accept personal financial responsibility for any charges not covered by his/her insurance.*
- *Be respectful of all the health care providers and staff, as well as the other patients.*

These rights and responsibilities are prominently displayed in the waiting area of the Center, and are also available, upon request, in an informational brochure.

***Note: Incorporates suggested language from Arizona State "Rules and Regulations for Ambulatory Care Facilities, Medicare Rules", JC and the" AAAHC Accreditation Handbook for

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