Athens Endoscopy, LLC

Patient Bill of Rights, Privacy Notice, and Disclosure

****ALL FACILITY PERSONNEL PERFORMING PATIENT CARE ACTIVITIES SHALL OBSERVE THESE ABOVE RIGHTS****

PATIENT BILL OF RIGHTS

The patents have a right to:

1. Receive considerate, respectful care and dignity in a safe setting.
2. Know the name of the medical provider responsible for coordinating his/her care. Patients have the right to change their provider if other qualified providers are available.
3. Obtain information from his/her medical provider in terms that can be reasonably understood, including-- but not limited to-- his/her evaluation, diagnosis, treatment, prognosis, advance directives that will not be accepted at the surgery center, and medically significant alternatives for care or treatment that may be available, to the degree known by the medical provider. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his/her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has a right to know the name of the person(s) responsible for the procedures and/or treatments. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons or emergencies. 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.
4. Obtain the necessary information from his/her medical provider so the patient may give his/her informed consent or refuse the procedure and /or treatment before the start of any procedure and /or treatment. Except in emergencies, this necessary information shall include but is not limited to, a description of the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved in the treatment, the provisions for after-hours/ emergency care, alternate course of treatment (if any), and risks of non-treatment.
5. Refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his/her decision.
6. Expect this accredited ambulatory surgical facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
7. Obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.
8. Be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care of treatment. The patient has a right to refuse to participate in research projects.
9. Every consideration for privacy throughout his/her medical experience, including but not limited to the following: Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatment/ procedures. Those not directly involved in his/her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential. Patients will be given the opportunity to approve or refuse their release except when release is required by law.
10. Expect reasonable continuity of care, including, but not limited to the following: The right to know in advance what appointment times and medical providers are available and where; The right to have access to information from his/her medical provider or designee regarding continuing health care requirements following discharge; The number to call for questions or emergency care.
11. To have access to and examine an explanation of his/her bill regardless of source of payment; to be informed of fees for services and payment policies advance, charity and indigent care policy, charges for services not covered by third-party payers, and credentials of health care professionals.
12. Have a family member, appointed representative or designated support person(s) of his/her choice be involved in all phases of his/her care. All the patient's rights apply to the person who has legal responsibility to make decisions regarding his/her medical care on behalf of the patient. The patient and the family member, appointed representative or designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.
13. Be free from all forms of abuse, neglect, or harassment.
14. Know his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient has a right to exercise his/her rights without being subjected to discrimination or reprisal.
15. Be informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations
16. Remain free from seclusion or restraints of any form that are not medically necessary. Patient may choose to leave the facility even against medical advice.

PATIENT RESPONSIBILITIES

The patient has the responsibility for:

a. providing complete and accurate information to the best of his/her ability about his/her health (i.e., complaints, past illnesses, hospitalizations, any other health related issues) , any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
b. making it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
c. following the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
d. Providing a responsible adult to transport him/her from the surgery center and remain with him/her for 24 hours, if required by his/her provider.
e. refusal of treatment and/or not following directions.
f. assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
g. being respectful of all the health care providers and staff, as well as other patients.
h. following facility policies and procedures.
i. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within Athens Endoscopy for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Athens Endoscopy receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Athens Endoscopy to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by Athens Endoscopy for the purposes of raising funds to support the organization's operations.
- You have the right to restrict the use of your confidential healthcare information. However, Athens Endoscopy may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Athens Endoscopy is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Athens Endoscopy will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Athens Endoscopy if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

PATIENT CONCERNS

Patients are encouraged to submit any concerns or complaints, in writing, to the Administrator of Athens Endoscopy. Please submit complaint to: **TanDeKaH Scott, Practice Administrator, Athens Endoscopy, LLC, 21 Jefferson Place, Suite 2, Athens, Georgia 30601**. You may also contact the **Athens Endoscopy Team Leader (706-433-0788)**. We will work to address & resolve the issue in a professional manner. You have the right to take concerns directly to: Quad-A (888-545-5222 or investigations@quada.org); The Georgia Department of Community Health (404-657-5726). Please refer to the posted addresses in the lobby.

ISSUES REGARDING MEDICARE

- Issues regarding Medicare: Office of the Medicare Beneficiary Ombudsman: 1-800-MEDICARE or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

****All complaints will be investigated. No issue will be raised for filing a complaint with the organization****
****For further information about this Privacy Notice, please contact:* ***Athens Endoscopy Team Leader (706-433-0788).********
****This notice is effective as of Date of Effectiveness. This date must not be earlier than the date on which the notice is printed or published****

OWNERSHIP

I understand that the physician(s) on staff at Athens Endoscopy providing medical services are in fact the owners of the facility. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Athens Endoscopy.

RELEASE OF INFORMATION

Athens Endoscopy is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physician of Athens Endoscopy. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Athens Endoscopy to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Athens Endoscopy all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to Athens Endoscopy. 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 Athens Endoscopy from the obligor of said benefits. Further, I hereby assign and convey Athens Endoscopy, unless charges for their services have been paid, so much of any cause of action or right of 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 Athens Endoscopy any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Athens Endoscopy. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Athens Endoscopy be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only. 7:30 AM to 4:00 PM, Monday through Friday. No medications will be refilled over the phone after hours or on the weekends. If you have an emergency situation, you will be directed to the emergency department at the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life threatening emergency. Athens Endoscopy is not equipped to determine if there is a life threatening event; patient will be treated and stabilized, and transported to the hospital of choice by ambulance. I consent to emergency transfer to the hospital in case of the need for emergency hospital care. A copy of the advance directive may be placed on the chart if the patient desires and forwarded to the hospital in the event of a transfer. Information regarding advance directives is made available upon the patient's request. The admitting facility is not affiliated or in partnership with Athens Endoscopy.

Do you have an advance directive? O **Yes** O **No ==> If no, would you like an advance directive form?** O **Yes** O **No**

I have received and understand the Patient Bill of Rights, Privacy Notice, and the Disclosures in this form.

Patient Name: _____ **Date of Birth:** _____

Patient/Guardian Signature: _____ **Date/Time:**_____