



KIPS BAY ENDOSCOPY CENTER, LLC

Patient Instruction Packet

**Please read the information in this packet at
least 5 DAYS prior to the time of your
scheduled appointment.**

**Please complete pages 17 – 31
and bring with you on the day of
your appointment.**

Kips Bay Endoscopy Center
535 2nd Avenue
New York, NY 10016
Telephone: 212 889-5477
Fax: 212 889-0517
www.kipsbayendo.com

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The forms listed below are enclosed in this packet and are required for your visit to the Center.

Please complete the forms on Pages 15 thru 23 and bring them with you on the day of your appointment.

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Welcome Notice

Welcome to the Kips Bay Endoscopy Center (KBEC). We are committed to ensuring that your endoscopic procedure is performed in a safe and comfortable manner. We pride ourselves on our state-of-the-art gastrointestinal endoscopy facility that allows us to perform your procedure using the latest equipment and most advanced techniques. Our caring staff are dedicating to treating you with compassion, dignity and respect.

In addition, KBEC anesthesiologists have access to the most up-to-date anesthesia technology to assure your safety and comfort. The Center is fully staffed with experienced registered nurses, endoscopy technicians and support staff. Further information can be found on our website at <http://www.kipsbayendo.com>.

Your physician's choice to use The Kips Bay Endoscopy Center for your endoscopic procedure reflects his or her confidence that our Center will provide the highest quality endoscopic and anesthesia services for your continued well-being. KBEC is committed to maintaining these high standards.

KBEC is accredited by the New York State Department of Health and the Accreditation Association for Ambulatory Health Care (AAAHC) as a freestanding ambulatory surgical care facility for endoscopic procedures. KBEC is also the first Endoscopy Center in New York to receive the Center of Excellence recognition.





KIPS BAY ENDOSCOPY CENTER, LLC

DIRECTIONS TO KIPS BAY ENDOSCOPY CENTER

Directions by car:

From Long Island and Queens

Merge onto I-495 W via the ramp on the left to L I Expy/Midtown Tun Partial toll road

Continue onto NY-495 W

Turn left at E 34th St - 456 ft

Take the 1st right onto 2nd Ave Destination will be on the right - 0.2 mi

From Brooklyn:

Take the exit onto I-278 E toward Bklyn-Qns Expy/Queens/Bronx

Take exit 28B to merge onto Brooklyn Bridge - 1.2 mi

Take the F D R Dr/Pearl St exit - 0.2 mi

Keep right at the fork, follow signs for F.D.R. Dr N and merge onto F D R Dr/E River Dr - 2.6 mi

Take exit 7 toward E20-E23 St - 0.3 mi

Turn right at Avenue C - 0.3 mi

Turn left at Fdr Dr/Fdr Drive Service Rd E - 82 ft

Continue onto E 23rd St - 0.2 mi

Turn right at 1st Ave - 0.3 mi

Turn left at E 29th St - 0.3 mi

Turn right at the 2nd cross street onto 3rd Ave - 282 ft

Take the 1st right onto E 30th St - 0.1 mi

Take the 1st right onto 2nd Ave - 128 ft

From NJ:

Take exit 16E toward Lincoln Tunnel/NJ-3

Keep left at the fork, follow signs for N J 3/Secaucus and merge onto NJ-495 E Partial toll road Entering New York - 3.6 mi

Continue onto NY-495 E - 0.8 mi

Take the exit toward Dyer Ave - 0.2 mi

Turn right at Dyer Ave - 0.1 mi

Turn left at W 34th St - 1.3 mi

Turn right at 2nd Ave - 0.2 mi

From CT

Take the exit onto I-95 S toward N.Y. City Entering New York - 45.8 mi

Continue onto I-278 W - 5.4 mi

Take the exit toward FDR Dr - 0.2 mi

Merge onto Triborough Bridge Partial toll road - 0.4 mi

Take the F D R Dr S ramp - 0.4 mi

DIRECTIONS TO KIPS BAY ENDOSCOPY CENTER (continued)

Directions by Subway

East Side – Lexington Avenue IRT #6 to 28th Street and Park Avenue

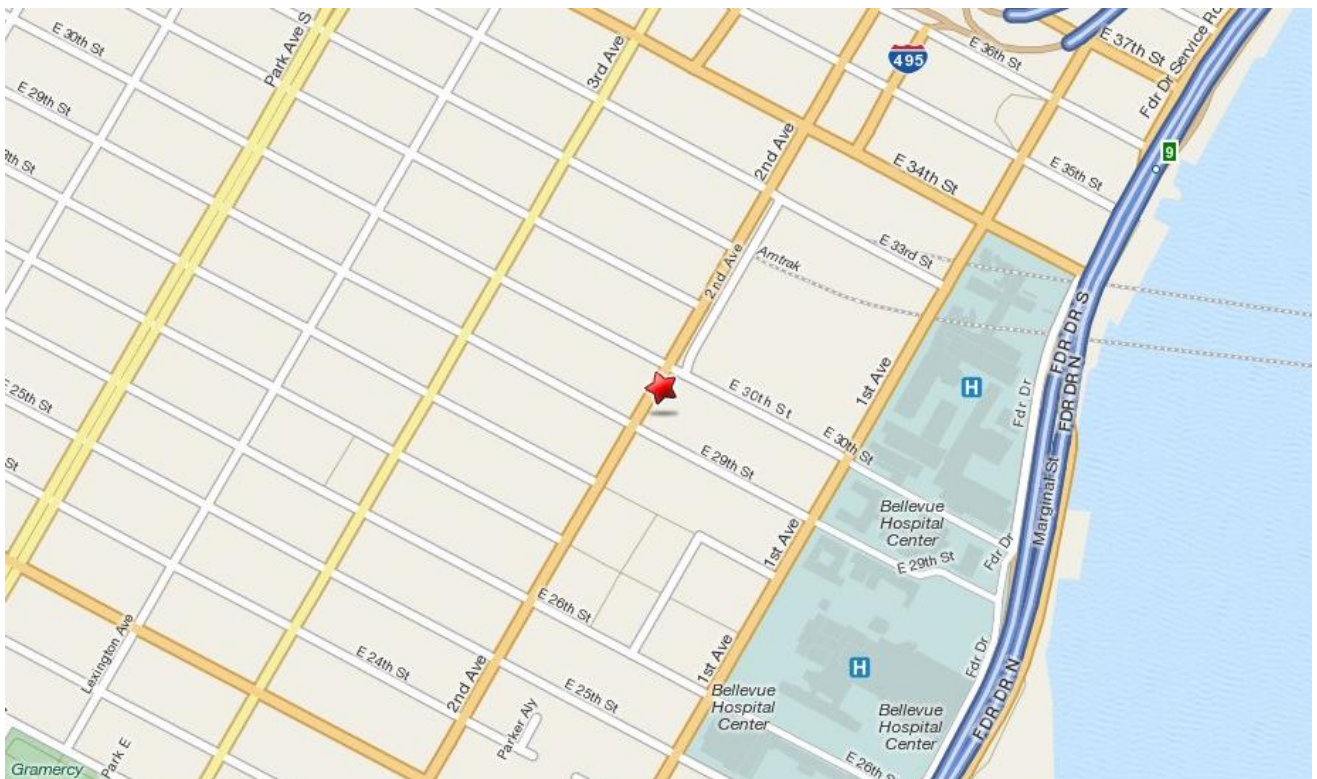
West Side – Subway to 42nd Street, Take shuttle to Grand Central Station, then #6 to 28th Street Station

Penn Station – 34th Street Cross-town Bus to 2nd Avenue

Grand Central Station – Lexington Avenue Bus to 30th Street

Parking Information

There is a parking lot on 30th Street between 3rd and 2nd Avenues and 29th Street between 1st and 2nd Avenues



PATIENT ESCORT POLICY

As a matter of patient safety, the Kips Bay Endoscopy Center enforces the New York State Ambulatory Surgical Center **requirement that all patients having a procedure in our facility have an escort**, that is, a companion, family member or friend, to accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888 943-8435) to arrange for a care partner to accompany you home from your procedure.

For additional information and to make arrangements for a care partner, you can visit the following website:

www.partnersincareny.org.

Or e-mail:

par_intake@vnsny.org.

Please note that your procedure cannot be performed unless your escort is verified.

Thank you for your cooperation.

PERSONAL POSSESSIONS NOTICE

Kips Bay Endoscopy Center will provide you with a private locker to safely store your personal belongings during the procedure. We strongly encourage you to use the locker provided.

Please **DO NOT** wear jewelry, **DO NOT** bring laptops, **DO NOT** bring iPods or any other valuables when you come to the Center.

Please note that Kips Bay Endoscopy Center assumes no responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.

PROCEDURE INFORMATION SHEET

An upper endoscopy or **EGD (EsophagoGastroDuodenoscopy)** involves the insertion of a lighted flexible tube, called an upper endoscope, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

A **colonoscopy** involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of an electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

Endoscopic Ultrasound, also known as EUS or Endosonography, is a specialized endoscopic study that enables your doctor to examine your stomach lining and the walls of your upper and lower gastrointestinal tract. EUS is also used to study internal organs next to the intestinal tract such as the Gall Bladder and Pancreas. The procedure is similar to routine endoscopy (EGD) or colonoscopy. A flexible tube is guided visually into the mouth or rectum. Then the EUS is used to scan and obtain ultrasound images. It is also possible to obtain tissue sampling via a fine needle aspirate (FNA) using real time ultrasound guidance.

EUS is generally a safe procedure, but carries several risks that include, but are not limited to, infection, perforation and bleeding. Serious complications of EUS, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure there are risks that may occur with any surgical or medical procedure.

There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

Further information about these procedures can be obtained at the following organization websites:

The American College of Gastroenterology:

www.acg.gi.org/patients/

The American Society for Gastrointestinal Endoscopy:

www.askasge.org

Frequently Asked Questions (FAQ's)

The following list of questions and answers may assist you in preparing for your procedure:

Q) I am having an upper endoscopy. Do I have to do anything to prepare for this procedure?

A) There is no specific preparation but you should not eat or drink anything after midnight the night before the test.

Q) My procedure is scheduled for the afternoon. Can I eat or drink anything the morning of the procedure?

A) You should not eat anything after midnight. You may have up to 1 cup of clear liquid four hours prior to your scheduled arrival time at KBEC.

Q) Will my procedure be painful?

A) No. The Center is fully staffed with Board-certified anesthesiologists to ensure that your procedure is comfortable.

Q) How long will I be at the Center?

A) You will be at the Center approximately 1 ¾ hours in total. You will spend less time at the center by making certain you are punctual for your appointment. Arriving earlier than your appointment time won't necessarily get you through faster, while arriving late will probably cause you to lose your scheduled time slot and create substantial delays for you. Completing the required paperwork (available on-line or by mail) prior to your arrival, will expedite the process.

Q) Do I have to bring an escort with me?

A) Yes. The Center requires that you have an escort to take you home.

Q) My doctor has all my insurance information. Do I need to bring my insurance card and billing information?

A) Yes. KBEC is an independent entity and has no connection to your doctor's office.

Q) Will I receive a bill?

A) Yes. We will bill your insurance company or HMO directly first. You will be billed for your co-payment, deductible and co-insurance.

****Please note that some insurance companies may send payment directly to you for the facility and anesthesia service. We expect that you will forward this payment directly to KBEC.**

FAQ's (continued): Special Medical Considerations

Q) Do I take my heart medications on the day of my procedure?

A) In general, you can continue to take prescribed medications before and after gastrointestinal endoscopy without modification. Essential medications may be taken on the day of your procedure with a small amount of clear liquid. There are some types of cardiovascular medications, however, that should not be taken on the day of your procedure; these include diuretics, ACE inhibitors, and angiotensin II receptor blockers. If you are unsure if the medications you take fall into these categories, please ask your physician or consult the following website: www.webmd.com/drugs.

Q) I am a diabetic. Should I take my medication on the day of my procedure?

A) In general, diabetic medication should **not** be taken on the day of your procedure. ***There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary physician.*** A finger stick blood sugar will be obtained by the KBEC staff to ensure proper management of your blood sugar during your procedure. When the procedure is over and you have resumed a normal diet, your usual diabetic regimen should be resumed.

Q) I have been told to take prophylactic antibiotics prior to dental work. Do I need to take antibiotics before my endoscopic procedure?

A) With rare exceptions, the procedures performed at KBEC do **not** require the administration of prophylactic antibiotics. If, however, you are advised by your physician to take antibiotics prior to gastrointestinal endoscopy, you may take them orally, 1 hour prior to the procedure, with a small amount of clear fluid. If you are uncertain if you require anti-biotics prior to your GI Endoscopy procedure or if you need a prescription, please call your doctor prior to your appointment.

Q) I take aspirin, or anticoagulants or other blood thinners. Do I need to stop these medications before my procedure?

A) In general, aspirin, anticoagulants and other blood thinners should be stopped at least 3 days prior to your procedure. This is to reduce the chance of bleeding if biopsies are obtained or polyps are removed. ***There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary physician.***

FAQ's (continued): Special Medical Considerations

Q) What if I am pregnant or may be pregnant – should I undergo gastrointestinal endoscopy?

A) If you are pregnant, you should consult with your physician about whether you should undergo gastrointestinal endoscopy. If you are a woman of child-bearing age, KBEC will administer a pregnancy test prior to your procedure in order to optimize your management.

Q) I am breast feeding my baby. Is the procedure safe for my baby?

A) In general, women who are breast feeding may safely undergo gastrointestinal endoscopy – the administered anesthetic is not excreted in significant quantities in breast milk. Some mothers elect to store milk via a breast pump and feed the child with the pumped milk on the day of the procedure. Normal breast feeding may resume the following day.



NOTICE OF PRIVACY PRACTICES

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.

I. What this Is:

This Notice describes the privacy practices of Kips Bay Endoscopy Center, LLC

II. Our Privacy Obligations

We are required by law to maintain the privacy of medical and health information about you (“**Protected Health Information**” or “**PHI**”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our “health care operations” (e.g., internal administration, quality improvement and customer service) as detailed below:

- **Treatment.** We use and disclose PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
- **Payment.** We may use and disclose PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“**Your Payor**”), or to verify that your Payor will pay for health care.
- **Health Care Operations.** We may use and disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our administrators in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Nurse Administrator.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person’s involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

M. Workers’ Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs.

N. As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Use and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form (“**Your Authorization**”). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child’s camp or school, or to the attorney representing the other party in litigation in which you are involved.

- B. Special Authorization. Confidential HIV-related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances, to public health or other government officials (as required by law), to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth in New York State law). This special written authorization ("**Your Special Authorization**") is a New York State approved form, which is a separate document from Your Authorization. There is only one type of disclosure of confidential HIV related information which is permitted with Your Authorization, as opposed to Your Special Authorization: disclosures to a third party payor for any reason other than obtaining payment for health care services rendered to you.
- C. Marketing Communications. We must also obtain your written authorization ("**Your Marketing Authorization**") prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

V. Your Individual Rights

- A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our Nurse Administrator. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Nurse Administrator will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.
- B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Nurse Administrator and submit the completed form to the Nurse Administrator. We will send you a written response.
- C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
- D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Nurse Administrator and submit the completed form to the Nurse Administrator. If you request copies, we will charge you **\$0.75** for each page copied.
You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).
- E. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Special Authorization, or Your Marketing Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Nurse Administrator identified below. **[A form of Written Revocation is available upon request from the Administrator.]**
- F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Nurse Administrator and submit the completed form to the Nurse Administrator. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.
- G. Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you **\$10.00 per page** of the accounting statement.
- H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

- A. Effective Date. This Notice is effective on April 14, 2003.

Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Center and on our Internet site at www.kipsbayendo.com. You may also obtain any revised notice by contacting the Administrator.

VII. Administrator: Elizabeth Yuen

You may contact the Administrator at:

Kips Bay Endoscopy Center, LLC
535 2nd Avenue
New York, NY 10016
Telephone Number: (212) 889-5477
Fax Number: (212) 889-0517
E-mail Address: EYuen@Kipsbayendo.com

Patient Rights & Responsibilities

The patient has the right to:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor.
2. Be treated with consideration, respect and dignity including privacy in treatment.
3. Be informed of the services available and applicable charges at the Center.
4. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
5. Be informed of the provisions for after hours and emergency care.
6. Receive an itemized copy of his/her account statement, upon request.
7. Obtain from his/her Health Care Provider, or the Health Care Practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
8. Receive from his/her Physician information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both. .
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
10. Refuse to participate in experimental treatment.
11. Voice grievances and recommend changes in policies and services to the Center's staff, the operator and the New York State Department of Health without fear of reprisal.
12. Express complaints about the care and services provided and to have the Center investigate such complaints. If the patient is not satisfied by the Center's response, the patient may complain to the New York State Department of Health's Metropolitan Area Regional Office (MARO) at 800 804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any Health Care Practitioner and/or Health Care Facility except as required by law or third-party payment contract.
15. Access their medical record pursuant to the provisions of the law.
16. To Execute an advance directive and
17. To receive pain management services

The patient has the following responsibilities:

1. To provide the Center with 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 allergies or sensitivities.
2. To ask all questions you may have regarding the treatment provided by the Center.
3. Provide a responsible adult to transport him/her home from the facility and if required by his/her provider, remain with him/her for 24 hours.
4. To consent by free will to all procedures.
5. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
6. To tell us if you do not understand procedures or instructions.
7. To follow after-care instructions as recommended by the Center.
8. To contact his/her Physician with post-testing questions or concerns.
9. To provide all necessary information regarding third-party payment sources.
10. Accept personal financial responsibility for any charges not covered by his/her insurance.
11. To observe all the Center's Policies and Regulations.
12. To keep appointments as scheduled, or advise the Center if the appointment cannot be kept.
13. To be considerate of other Patients and Personnel and respect the property of others and the Center.



PATIENT REGISTRATION

Today's Date _____ Date of Birth _____ Age _____ Social Security# _____ (or last 4 digits)

Patient Name _____ Gender M F Marital Status S M W D (First Name) (MI) (Last Name)

Address _____ (Street) (Apt#) (City) (State) (Zip Code) (County)

Home Phone _____ Cell Phone _____ Alternate Phone _____ E-mail Address _____

Employer _____ Occupation _____ Work Phone _____

Address _____ (Street) (City) (State) (Zip Code)

Ethnicity - Do you consider yourself Hispanic/Latino? Y ___ N ___ Declined ___ Unavailable/Unknown ___ Primary Language _____

Race - Which category best describes your race? ___ American Indian/Alaskan Native ___ Asian ___ Black or African American ___ White ___ Native Hawaiian/Pacific Islander ___ Multiracial ___ Declined ___ Unavailable/Unknown

Emergency Contact _____ Relationship _____ Telephone _____ Cell Number _____

Name of the person who will escort you upon discharge from the Center Phone number Cell Phone number

Send Report to Dr.: _____ Address _____

Referring Physician Telephone _____ Referring Physician Fax _____

Do you have any allergies? [] Yes [] No Allergies to Latex? [] Yes [] No Allergies to food? [Please list] _____

Allergies to medications? [] Yes [] No [Please list drug names] _____

Primary Insurance Company Name _____ [] Hosp [] Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ Date of Birth _____ SS # _____ Relationship _____

Secondary Ins. Company Name _____ [] Hosp [] Medical Ins Phone # _____

Address _____ Group # _____ ID # _____

Name of Insured _____ Relationship _____ DOB _____ SSN# _____

I, the undersigned, have insurance with _____ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient's signature: _____

Do You Have A Health Care Proxy [] No [] Yes If Yes, Type: _____ Copy Provided? [] No [] Yes

Do You Have A Living Will? [] No [] Yes If Yes, Type: _____ Copy Provided? [] No [] Yes

By signing below, I acknowledge receiving a copy of the Center's Notice of Privacy Practices and Patients' Bill of Rights and Responsibilities.

Patient's Signature: _____

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter's Signature: _____

Pre-Endoscopy Questionnaire

Name: _____

Date: _____

1. Do you have any medical conditions we should be aware of? Yes ____ No ____

If yes, please explain: _____

2. Do you take prescribed medications? Yes ____ No ____

If yes, list the medications with dosages. _____

Please list over-the-counter medications or herbal supplements that you take on a regular basis. _____

Please list all medications you have taken or will take on the day of your procedure. _____

3. Do you have any allergies to medications or drugs? Yes ____ No ____

If yes, please list. _____

4. Do you have any food allergies? i.e. eggs or soy Yes ____ No ____

5. Do you take aspirin products on a regular basis? Yes ____ No ____

If yes, these products may need to be discontinued. Please consult your physician.

6. Do you take non-steroidal anti-inflammatory products on a regular basis? Yes ____ No ____

(I.E. - Advil, Motrin, Aleve, Naprosyn, Mobic, Clinoril, Celebrex)

If yes, these products may need to be discontinued. Please consult your physician.

7. Do you take coumadin or any other anti-coagulant medications? Yes ____ No ____

If yes, these products may need to be discontinued. Please consult your physician.

8. Do you have diabetes? Yes ____ No ____

9. Do you take insulin? Yes ____ No ____

10. Do you have a heart condition? Yes ____ No ____

If yes, please explain. _____

11. Have you ever been told to take antibiotics prior to a procedure? Yes ____ No ____

If yes, have you taken antibiotics prior to your scheduled procedure? Yes ____ No ____

12. Have you ever had a bleeding problem? Yes ____ No ____

13. Have you ever had surgery? Yes ____ No ____

If yes, please explain. _____

14. Have you ever had problems with anesthesia? Yes ____ No ____

If yes, please explain. _____

15. Have you ever had an endoscopic procedure? (colonoscopy or gastroscopy) Yes ____ No ____

If yes, please provide details. _____

16. Is there any other information we should know about? Yes ____ No ____

Completed by: _____ Date: _____

Kips Bay Endoscopy Center Personnel _____

<input type="checkbox"/> No pre-procedure testing required <input type="checkbox"/> Pre-procedure testing needed (specify): _____ Reviewed by: _____ Signature/title _____ Date _____



OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to you home or place of work.

Statutory authority; *Public health law, §238 a (10)*

The Following Physicians Are The Owners Of The Center:

- John Ackert, MD
- Howard Adler, MD
- Robert Bearnot MD
- Jerome Breslaw, MD
- Edward Brettholz, MD
- Armand Cacciarelli, MD
- Jonathan Cohen, MD
- Hal Freiman, MD
- Charles Friedlander, MD
- Todd Linden, MD
- Ian Lustbader, MD
- James Salik, MD
- Alex Sherman, MD
- Charles Silvera, MD
- Anthony Starpoli, MD
- Hillel Tobias, MD
- Scott Weber, MD

I, _____, confirm that I have read and fully understand the above statements that have been presented/told to me in this document.

Signature

Date

PATIENT SELF-DETERMINATION ACT/ADVANCE DIRECTIVES

Kips Bay Endoscopy Center supports each patient's right to develop an advance directive; the Center will not condition the provision of care or discriminate against an individual based on whether or not an advance directive has been executed; and will provide education for its staff, patients and the community, as applicable, related to the patient self-determination act/advance directives.

If you are interested you may request resource information regarding self-determination. The information includes:

- The description of state law prepared by the Department of Health entitled, "Planning In Advance For Your Medical Treatment".
- The pamphlet prepared by the department of health entitled, "Appointing Your Health Care Agent - New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding About CPR Do Not Resuscitate Orders (DNR)".
- A handout entitled, "Ten Basic Questions And Answers For Consumers On The Patient Self-Determination Act".
- A handout entitled, "Definitions For A Health Care Proxy".

Our staff will inquire and document your present status concerning advance directives during the pre-procedure assessment in the medical record.

If you have executed an advance directive and have brought a copy, this copy will be filed in your medical record.

If copies are not immediately available, the types of advance directives and the name and address of the healthcare agent are obtained and documented in your medical record.

If you request additional information or wish to make an advance directive, the Center will supply you with appropriate information and direction.

The Center will comply with the health care decisions made in good faith by a health care agent to the same extent as decisions made by a competent adult.

Financial Policy

Your physician has chosen to perform your endoscopic procedure(s) at the Kips Bay Endoscopy Center [KBEC]. KBEC is a freestanding ambulatory surgical center [ASC] subject to New York State regulations. It is not associated with your doctor's office and has separate financial and billing policies and procedures.

KBEC will charge you for its facility and anesthesia services. Please understand that you are responsible for paying your bill(s) in connection with your treatment at the time of registration. You will also receive a separate bill from your physician for your endoscopy procedure and a separate bill for applicable laboratory services. Your physician's and laboratory charges are independent of the KBEC charge.

The following is a statement of our Financial Policy that we require you read and sign prior to your treatment at KBEC.

While your physician may participate in your insurance plan, KBEC may or may not participate with your insurance plan. Prior to the date of your procedure, please verify the details of your insurance coverage with your insurance carrier. To further understand KBEC's policy, please review the following:

- 1) **If KBEC participates with your insurance plan**, the fees for your services will be billed to your insurance plan. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance at the time of your procedure. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.
- 2) **If KBEC does not participate with your insurance plan**, KBEC will bill your insurance plan. If you have "out-of-network" coverage, your insurance plan may cover a part of this charge. You are responsible for the payment of your deductible as well as any unpaid balance and KBEC will bill you accordingly. If you have no "out-of-network" coverage, you will receive a bill from KBEC for the facility fee and anesthesia fee. You are required to make payment arrangements prior to your procedure.
- 3) **KBEC participates with the Medicare program.** If you have Medicare coverage, you will be responsible for payment of the unmet deductible and the remaining 20 percent of the approved charge. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.
- 4) **Some insurance plans will send KBEC's facility and anesthesia payments directly to you.** If you receive the payments for the services you received at KBEC, you are responsible for forwarding the check directly to KBEC. It is your responsibility to ensure the Center is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting the payments to KBEC constitutes a breach of contract and KBEC will pursue all legal remedies available to it to obtain such payments.

_____, _____ reviewed this policy with the patient.
(Name) (Title)

Signature of Patient or Responsible Party

Date



UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: _____ Med. Rec. #: _____

Physician: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above named medical facility, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Kips Bay Endoscopy Center, LLC, to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the release of all my medical records pertaining to that transfer or admission to Kips Bay Endoscopy Center, LLC.

Signature of Patient or Authorized Representative

Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named medical facility sufficient monies and/or benefits to which I may be entitled for government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

Signature of Patient or Authorized Representative

Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Title XVIII of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

Signature of Patient or Authorized Representative

Date



Notifier(s):

Patient Name: _____

Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:			
Reason Medicare May Not Pay:			
Estimated Cost:			

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.	
<input type="checkbox"/> OPTION 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.	
<input type="checkbox"/> OPTION 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment , and I cannot appeal to see if Medicare would pay.	

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____	Date: _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Acknowledgment of Advance Notice

I herby acknowledge receipt of the Center’s Notice of Privacy Practices and acknowledge that the Center may use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and performing routine healthcare operations and services in the Center.

By signing below, I herby acknowledge that I received written the notices below at least 24 hours in advance of my procedure.

- Notice of Privacy Practices
- Patient’s Bill of Rights and Responsibilities
- Ownership Disclosure
- Advance Directives

I understand that I am required to bring an escort to take me home on the day of the procedure.

I understand that I may be financially responsible for any outpatient facility charges, as outlined in my insurance coverage for copayments, coinsurance and deductibles.

First Name	M.I.	Last Name
Signature		Date
Witness		Date
Interpreter		Date