METRO ATLANTA ENDOSCOPY, LLC

PATIENT RIGHTS

1. Patients are treated with respect, consideration and dignity.
2. Full consideration of patient privacy concerning consultation, examination, treatment and surgery.
3. To have considerate and respectful care, provided in a safe environment.
4. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may use an appointed representative.
5. Have a family member or representative of his/her choice be involved in his/her care.
6. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient
7. Remain free from seclusion or restraints of any form that are not medically necessary.
8. Coordinate his/her care with physicians and healthcare providers they will see; patients have the right to change their provider if other qualified providers are available.
9. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. 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.
10. Patient will receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment of non-treatment and the risks involved.
11. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
12. Be informed by physician or designee to the continuing healthcare requirements after discharge.
13. Confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law.
14. Access information to his/her medical record within reasonable time frame (48 hours).
15. May leave the facility even against medical advice.
16. Patients are informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
17. Examine and receive an explanation of the bill regardless of source of payment.
18. Exercise these rights without regard to race, sex, cultural, educational or religions background or the source of payment for care.
19. Informed regarding: patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for services, payment policies, right to refuse participation in experimental research, advance directives will be accepted at the surgery center, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals

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

PATIENT RESPONSIBILITIES

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.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of Metro Atlanta Endoscopy, LLC. Please submit complaint to:

Metro Atlanta Endoscopy, LLC
5669 Peachtree Dunwoody Rd, Suite 210
Atlanta, GA 30342
404-255-4333

If the complaint is not resolved to the patient's satisfaction he/she has a right to file a grievance with the Georgia Department of Community Health, Complaints Unit for concerns against the surgery center, the Composite State Board of Medical Examiners concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should either call any of the complaint units or send a written complaint. The patient should provide the physician or surgery center name, and address and the specific nature of the complaint.

COMPLAINTS AGAINST THE ASC:

Georgia Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142
P: (404) 657-5726; P: (404) 657-5728
ONLINE:
https://services.georgia.gov/dhr/reportfiling/searchFacility.do?action=constituentComplaint

Joint Commission
Office of Quality Monitoring
One Renaissance Blvd
Oakbrook Terrace, IL 60181
800-994-6610

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303
P: (404) 657-6494; (404) 656-1725
F: (404) 463-6333
ONLINE FORM:
https://versa.medicalboard.georgia.gov/datamart/gadchComplaint.do?from=loginPage
MAILED FORM: http://www2.files.georgia.gov/GCMB/Files/CP%20Form%20022010.pdf

Issues regarding Medicare :
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html or call

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858
P: (478) 207-2440
ONLINE:
https://secure.sos.state.ga.us/myverification/SubmitComplaint.aspx

1-800-MEDICARE.

+METRO ATLANTA ENDOSCOPY, LLC

HIPAA 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 Metro Atlanta Endoscopy, LLC for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Metro Atlanta Endoscopy, LLC 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 pubic 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 Metro Atlanta Endoscopy, LLC 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 Metro Atlanta Endoscopy, LLC 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, Metro Atlanta Endoscopy, LLC 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 request 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.
- Metro Atlanta Endoscopy, LLC 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.
- Metro Atlanta Endoscopy, LLC 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 Metro Atlanta Endoscopy, LLC if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

COMPLAINTS AGAINST THE ASC:

Georgia Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142
P: (404) 657-5726; P: (404) 657-5728
ONLINE:
https://services.georgia.gov/dhr/reportfiling/searchFacility.do?action=constituentComplaint

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Tel: 847.853.6060
Fax: 847.853.9028
Email: info@aaahc.org

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303
P: (404) 657-6494; (404) 656-1725
F: (404) 463-6333
ONLINE FORM:
https://versa.medicalboard.georgia.gov/datamart/gadchComplaint.do?from=loginPage
MAILED FORM:
http://www2.files.georgia.gov/GCMB/Files/CP%20Form%20022010.pdf

ISSUES REGARDING MEDICARE: 1-800-MEDICARE or online at
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858
P: (478) 207-2440
ONLINE: https://secure.sos.state.ga.us/myverification/SubmitComplaint.aspx

All complaints will be investigated. No issue will be raised for filing a complaint with the organization.
Issues regarding Medicare: www.cms.hhs.gov/center/ombudsman.asp or call 1-800-MEDICARE.

For further information about this Privacy Notice, please contact Metro Atlanta Endoscopy, LLC.

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.

_____ _____

Patient Signature Date & Time

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Contact#:_____

TO: METRO ATLANTA ENDOSCOPY, LLC

(Person(s) or Organization(s) authorized to provide the information)

Please release my Protected Health Information to:Metro Atlanta Gastroenterology, LLC
FAX:404-255-0601ADDRESS:5669 Peachtree Dunwoody Rd., Suite 210, Atlanta, GA 30342

(Person(s) or Organization(s) authorized to receive the information)

Specific description of the information that may be used or disclosed

Endoscopy Reports_____ Pathology Results_____

All Records_____ Other_____

Specific description of how the information will be used: Medical Treatment

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1) I understand that this authorization will **not expire until I revoke my authorization.**
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Metro
Atlanta
Gastroenterology

Metro Atlanta Endoscopy, LLC

Metro Atlanta Endoscopy, LLC

Re: Important Financial Information

Dear Patient,

Metro Atlanta Gastroenterology will make every possible attempt to notify your insurance carrier of your upcoming procedure(s) and obtain the necessary 'Pre-Certification' and approval**.**

We strongly recommend that you contact your insurance company to review your benefits well in advance of your procedure.

It is important that you understand that you are responsible for the following:

> **Contacting your insurance carrier prior to your procedure(s) regarding your Benefits, Deductible, Co-Insurance, and or Co-pay. Our policy is to collect 50% of patient responsibility approx. 48 hours before your procedure and the other 50% at the time of your procedure.**
>
> In the event that you are unable to make your scheduled appointment; we require **72 hour notification (3-business days),** that you have elected to cancel/reschedule your procedure. Failure to do so will result in receiving a bill for a **$250.00 No Show Charge.** {Cancellation/Rescheduling will not be accepted via the Answering Service, you must call (404) 255-9184}.

The fee for services quoted by our office is an **estimate** of the Physician ***and*** Facility fee for the recommended procedure(s), based on information obtained from your insurance carrier. It is possible that the level of service may increase during your procedure to a higher level of care. This would be at the discretion of your physician in order to provide you with the highest level of quality care. In the event such changes occur, your insurance carrier will be billed accordingly, and any associated patient responsibility will be billed as required.

In addition to receiving a bill for the physician, you may receive a bill from the:

- Hospital
- Anesthesiologist
- Pathologist.

By signing my name I acknowledge that I have read and understand my responsibilities, and agree to the terms. **I also understand that I must have a driver with me for my procedure if I am going to have sedation. The driver must sign you out and accept responsibility for your safety.**

Patient Signature: _____ **Date:** _____

03/21/14

METRO ATLANTA ENDOSCOPY, LLC

PATIENT NAME: _____

OWNERSHIP

I understand that Drs. Carson, Shapiro and Weinstein are in fact the owners of the Metro Atlanta Endoscopy LLC.
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 Metro Atlanta Endoscopy, LLC.

RELEASE OF INFORMATION

Metro Atlanta Endoscopy, LLC 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 Metro Atlanta Endoscopy, LLC. 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 Metro Atlanta Endoscopy, LLC 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. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Metro Atlanta Endoscopy, LLC all surgical, medical insurance and/or other benefits, if any, and otherwise payable to me for the services. I agree to endorse the check(s) over to Metro Atlanta Endoscopy, LLC. 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 Metro Atlanta Endoscopy, LLC from the obligor of said benefits. I understand that payment is due when services are rendered. I assign all medical and/or surgical benefits including major medical benefits for services provided to Metro Atlanta Endoscopy, LLC. 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 Metro Atlanta Endoscopy, LLC 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 for medications may be issued based on the results of your procedure. No medications will be refilled. Please contact your physician's office to request a refill if needed. 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.

PATIENT BILL OF RIGHTS NOTICE

I have received and understand the Patient Bill of Rights.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the Administrator of Metro Atlanta Endoscopy, LLC.The Administrator may be reached at 404-255-4333. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights. Patient will be kept up-to-date on the grievance status.

ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life threatening emergency. Metro Atlanta Endoscopy, LLC 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 Metro Atlanta Endoscopy, LLC.

_____	_____	_____AM/PM
Patient Signature or Responsible Party	Date	Time

_____
Relationship if not the patient