5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

DIRECT ACCESS SCREENING COLONOSCOPY

Our direct access colonoscopy program allows you to schedule a colonoscopy without a prior consultation with the Endoscopist. This program is for patients new to Metro Atlanta Gastroenterology who are ***healthy*** adults who have no symptoms.

Dr. Jennifer Curtis is the physician who conducts our direct access colonoscopies.
If you are an existing patient who would like to participate in this program, please contact your physician's medical assistant to see if your doctor will approve participation.

This program is NOT for patients who:

- Are receiving anticoagulants
- Have had a stroke or TIA
- Have a pacemaker, defibrillator or have an extensive cardiac history
- Have kidney problems
- Have unstable COPD or Diabetes
- Have had issues with sedation in the past

If you would like to participate in our Direct Access Screening Colonoscopy program please read and complete the following pages and fax to 404-255-0601 along with a copy of both the front and back of your insurance card. A member of our staff will review your information and contact you to either schedule your procedure or to inform you that you do not meet the criteria and schedule a consultation with the doctor.

Metro Atlanta Gastroenterology
Metro Atlanta Endoscopy, LLC

PLEASE PRINT

Last Name: ______________________ **First**: ______________________ **MI**: ______

Address: ____
Street City Zip Code

Home Phone #: __________________ Cell Phone #: __________________ Email______________________

Birthdate ____________ Sex: _____ Marital Status: ______ Race________ Ethnicity__________ Language____________

Preferred method of contact (check one) Phone ______ Email ________ Postal Mail _______

Reason for Visit / Chief Complaint: ____

Referring Physician/PCP/Internist: ______________________ Phone: ( ) __________________

Address: ______________________________________ Fax: ( ) __________________

Insurance Information:

{Primary Insurance}

Policy Holder: ______________________ Social Security # (Last Four Digits)__________________ Birthdate ______________

Relationship: __________________

Patient Employer:

Employer/Position: ____

Address: ____

City, State, Zip Code: ____

Spouse Information:

Name______________________________ Birthdate______________

Employer______________________________Work Phone________________Cell Phone__________________

Emergency Contact:

Name: ______________________________ Phone: __________________ Relationship: ______________

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDs confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign medical and/or surgical benefits to which I am entitled to the following physicians: Drs. Carson, Weinstein, Shapiro, and Curtis. **I understand I am fully responsible for all fees not covered by my insurance. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (33.33%), reasonable attorney fees, court costs, etc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I have received a copy of Metro Atlanta Gastroenterology & Metro Atlanta Endoscopy practice policies covering appointments, after hours, prescription and insurance responsibilities.

____

Signed (Patient or Parent if Minor) **Date**

5669 Peachtree Dunwoody Road NE, Suite 210 Atlanta, GA 30342 (404) 255-4333 / Fax: (404) 255-0601

Metro Atlanta Gastroenterology, LLC
5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

Name: ______________________________ Age:________ Date of Birth:___________ Date:____________

Occupation: ______________________________ Height:_____________ Weight: __________________

Have you been having any of the following symptoms?

YES	NO		YES	NO	
☐	☐	Poor appetite	☐	☐	Heart Attack
☐	☐	Unintentional Weight Loss	☐	☐	Endocarditis/ Infected Heart Valve
☐	☐	Unintentional Weight Gain	☐	☐	Defibrillator Placement/Pacemaker
☐	☐	Fevers, Chills or Sweats	☐	☐	Heart Valve Replacement
☐	☐	Difficulty Swallowing	☐	☐	Mitral Valve Prolapse
☐	☐	Painful Swallowing	☐	☐	Palpitations/ Irregular Heart Beat
☐	☐	Heartburn/ Indigestion	☐	☐	Pain in Calves when Walking
☐	☐	Regurgitation of liquid/ food	☐	☐	Weakness/ Numbness
☐	☐	History of Ulcers	☐	☐	Blacking out Spells
☐	☐	Recurrent Vomiting	☐	☐	Seizures
☐	☐	Abdominal Pain	☐	☐	Chest Pain/ Tightness
☐	☐	Recurrent Constipation	☐	☐	Shortness of Breath
☐	☐	Recurrent Diarrhea	☐	☐	History of Sleep Apnea/CPAP
☐	☐	Blood in Stool	☐	☐	Blood in Urine
☐	☐	Hemorrhoids	☐	☐	Painful Urination
☐	☐	Rectal Pain	☐	☐	History of Kidney Problems
☐	☐	Jaundice	☐	☐	Arthritis/ Joint Pain
☐	☐	Excessive Bleeding	☐	☐	Recurrent Skin Rash
☐	☐	History of Blood Transfusion	☐	☐	Panic Attacks/ Anxiety
☐	☐	Anemia	☐	☐	Depression
☐	☐	Easy Bruising	☐	☐	History of Thyroid Disease
☐	☐	Stent or Graft placement	☐	☐	Hair Loss

Please list any past/ present medical problems & date (diabetes, high blood pressure, heart attack, etc.)

Date	Medical Problem	Date	Medical Problem

Please list any operations or hospitalizations & approximate year

Year	Operation/ Hospitalization	Year	Operation/ Hospitalization

Do you or have you ever:			
Smoked?	☐ Yes	☐ No	Packs per day _______/ years smoking _______
Used Snuff, Chew, Pipes, Cigars?	☐ Yes	☐ No	
Drink Alcohol?	☐ Yes	☐ No	What type and how much/week?

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children?	Number ______ Ages ____________ Last Menstrual Period _______			

Has anyone in your FAMILY had:			
☐ Colon Polyps	☐ Uterine Cancer	☐ High Blood Pressure	☐ Other ___
☐ Colon Cancer	☐ Bladder Cancer	☐ Heart Attack	___________
☐ Ulcerative Colitis	☐ Stomach Cancer	☐ Stroke	___________
☐ Crohn's Disease	☐ Ulcers	☐ Pancreatitis	___________
☐ Breast Cancer	☐ Diabetes	☐ Anemia	___________
☐ Liver Disease	☐ Bleeding Disorder	☐ Hemochromatosis	___________
☐ Ovarian Cancer	☐ Heart Disease	☐ Celiac Sprue	

Have you had any previous Gastrointestional studies/tests? When /where?

☐ Stool testing____

☐ CAT scan or MRI____

☐ Upper GI series____

☐ Colonoscopy____

☐ Upper Endoscopy (EGD)____

☐ Ultrasound____

Medications (Please list all over the counter meds, vitamins, and prescriptions)

Your procedure will be performed using Propofol. Have you ever had a problem with sedation or anesthesia? ☐ YES ☐ NO **If YES, please explain:**

Allergies to any medications

Pharmacy name and number:____

Secure phone number we can leave a voicemail regarding any medical information:_______________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________________________ Date ____________________________

Provider ____________________________________ Date ____________________________

The following form is now required due to legislation in relation to the Affordable Healthcare Act and will keep the practice of Metro Atlanta Gastroenterology and Metro Atlanta Endoscopy in compliance with government regulations. Its purpose is to protect the provider and the patient. REFUSAL TO SIGN THE FORM RENDERS THE PROVIDER UNABLE TO FILE ANY INSURANCE ON THE PATIENT'S BEHALF.

GENERAL POINTS FOR

ASSIGNMENT OF BENEFITS FORM

1. The designation of the Provider or the provider's representative (billing department) as attorney-in-fact is for the LIMITED PURPOSE ONLY of pursuing receipt of reimbursement from insurance company for services rendered. This includes filing of claims, providing medical records and pursuing appeal of denials.
2. The form details what was inferred previously by patient's contract with the insurer and the Provider's contract with the same; i.e. the Provider has the right to pursue collection of all funds patient is responsible for under in-network provisions, and all funds in totality for out of network services. The Provider also has the right to turn the patient over to an outside collection agency should the patient not meet their financial obligations.
3. The form further details that the Provider has the right to issue a complaint to any state or federal agency that has jurisdiction over the patient's health plan, in the event that the health plan does not meet their contractual obligations. This specifically refers to the Federal Government in the cases of Medicare replacement policies.
4. By signing the form, the patient is also attesting to the fact that the insurance information provided is current and correct. Again, if fraudulent insurance information is provided, the Provider has the right to turn the patient over to an outside collection agency for pursuit of payment.
5. This form is ONLY effective for the duration of the patient's care in our practice. Should the patient leave the practice, the form is rendered null and void without any further action having needed to be taken on behalf of the patient.

Assignment of Benefits Form – Metro Atlanta Gastroenterology

I ______________________ **(Print Name)** with insurance benefits through **(Policy Name)** ________________ (Medicare, Medicaid, or Individual Plan) as well as my governing Health and Welfare Plan or any Social Security Act, including title XVIII of the Social Security Act, hereby appoint as my authorized representative in connection with my claim for all medical services requested and rendered, as well as all entitled benefits and protected rights under my Plan or Policy related to all services rendered or requested. I authorize the above named provider or any appointed business associate acting under a valid business associate agreement to make any request for appeal on my behalf, present or to elicit evidence; to obtain all appeal correspondence and findings; and to receive all notifications in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to an appointed business associated to act on my behalf as my appointed authorized representative. I authorize all entitled benefits under my Plan/Policy to be paid directly to the provider listed above for all services rendered. I understand that I am entitled to all benefits that my Health and Welfare or Social Security Plan is legally obligated to provide, including any legal claim to benefits under the governing Plan. I understand that my Plan Sponsor and Health Insurance Issuer are required to accept and honor this agreement for all services rendered, in full compliance of all governing state and federal laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; as well as state and federal law related to all services rendered. I understand this authorization also covers any and all other providers of service directly associated with services rendered and requested by the above provider, including but not limited to all other providers involved with surgical related services, including surgical assistants, anesthesiology services, diagnostic testing, labs, pathology, radiology, implants, tissues, or any other services rendered or requested by the provider above and entitled under my governing or Federal covered health Plan. I appoint and authorize the above provider and business associate appointed by the provider as my duly authorized and personal representative relating to all services rendered, rights of appeal, disclosure and remedies due me under law. I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I understand that failure to provide accurate insurance information and coordination of benefit coverage at time of service or any failure to cooperate with the provider to the fullest extent to obtain full entitled reimbursement for all services rendered will result in my full financial responsibility of all services rendered. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all governing and applicable laws. I agree to cooperate with all providers listed in this agreement in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with provider against such insurers and/or employee health care plan for failure to pay all entitled benefits or provide all protected rights.

Thereby irrevocably, designate, authorize and appoint the Provider listed above or any appointed business associate as assigned by the provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of assuring receipt of all entitled benefit payments, rights of appeal, disclosure and remedies due under my governing Health and Welfare or Federal Healthcare plan or Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider/s has received payment in full and all rights as entitled under my governing Plan and in full compliance of governing federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my Plan and insurer unequivocal assignment and transfer of all entitled plan benefits, all rights under the Plan and federal law of appeal, disclosure, remedies and litigation due me to the Provider listed above and any appointed business associates working with them for the sole purpose of making sure all entitled benefits and rights under my specific health and welfare plan of governing law are administered in full compliance and to the extent of governing law. This authorization includes all protected rights under applicable governing law to receive entitled benefits, submittal of evidence, receive requested disclosures, to give or receive any notice related to benefits and rights, receive copies of all relevant documents and data pertaining to my claim and appeal submittals, receive governing plan documents, remedies, request administrative reviews, litigation, or make any statement of fact and law on my behalf to the extent consistent with Federal and state law. This is a direct unequivocal assignment of all rights and benefits under the governing plan/policy/Social Security Act. I understand this payment will not exceed my indeptedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits applicable to governing federal and state laws are paid. I hereby instruct and direct my Plan or Health Insurance Issuer to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make the check out to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including any and all medical records required for a full and fair review to any business associate, insurance company, adjuster, Plan Sponsor, Plan Administrator, governmental agency or attorney involved or responsible for making sure all protected rights and entitled benefits are provided. I authorize duly authorized representative to initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to the Provider acting as my personal representative. I understand that this assignment will remain in effect until revoked by me in writing except to the extent that the covered entity has already used or disclosed information under the authorization or (b) if the authorization was obtained as a condition of insurance coverage, or other law that provides the insured with the right to contest a claim under the governing Plan/policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

______________________ ______________________________ ____________

Signature of Patient/Guarantor **Full Address (Required by Some Insurance Plans)** **Date**

(Print Name at Top)

Metro Atlanta Gastroenterology, LLC
5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment , or Healthcare Operations

I understand that as part of my health care, Metro Atlanta Gastroenterology and Metro Atlanta Endoscopy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which my insurance carrier can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of Healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I further understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should the practice or endoscopy center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email)

I wish to have the following restrictions to the use or disclosure of my health information:

____
____
____

I understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent.

____
Patient's Signature Date

OVER

HIPAA RELEASE OF MEDICAL RECORDS
TO DESIGNATED INDIVIDUALS

I hereby authorize one or all of the designated parties listed below to request and receive the release of any health information regarding my treatment, payment or administrative operations related to the treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Do not include physicians, or insurance companies, only family/friends.

Authorized Designees:

Name:______________________________ Relationship:_________________________.

Name:______________________________ Relationship:_________________________.

Name:______________________________ Relationship:_________________________.

Name:______________________________ Relationship:_________________________.

____
Patient Name

____
Patient Signature

____
Date

**When leaving a message pertaining to your medical records, what is the best number with which to contact you.

____**

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

Metro Atlanta Gastroenterology, LLC
5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

PATIENT NAME: ______________________________

OWNERSHIP

I understand that Dr.'s Horney, McGahan, 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

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. Reasonable attempts are made for health care professions and staff to communicate In the language or manner primarily used by patients. 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

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.

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, Georgia 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

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

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://medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html or call 1-800-MEDICARE

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

______________________________ Patient Signature

______________________________ Date

______________AM/PM Time

METRO ATLANTA GASTROENTEROLOGY, LLC
5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

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, if required.

WE STRONGLY RECOMMEND THAT YOU CONTACT YOUR INSURANCE CARRIER 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 at the time of scheduling regarding your benefits, deductible, co-insurance, co-pay and precertification requirements. Our policy is to collect 50% of estimated patient responsibility 72 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 three business days notification 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. You must call 404-255-9184 during business hours to cancel.

The fee for services autoed by our office is an ***ESTIMATE*** of the Physician and Facility fee based on information from your insurance company. 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 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 and facility, you may receive a bill from the:

- Hospital and Anesthesiologist (if you are having your procedure at Emory St. Joseph's Hospital)
- 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:__________

Metro Atlanta Gastroenterology, LLC
5669 Peachtree Dunwoody Road, Suite 210 • Atlanta, GA 30342
office 404-255-4333 • endo. ctr. 404-255-4346 • metroatlantagastro.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use/disclosure of health information about me as described below.

Patient Name:_______________________________________

Date of Birth:__________ Contact Phone #:_______________

To and From: Metro Atlanta Endoscopy, LLC

To and From: Metro Atlanta Gastroenterology

This will allow your personal health information to be shared between the doctor's office and the endoscopy center.

I understand that:

- This authorization will not expire until I revoke my authorization.
- I may revoke this authorization at any time by notifying the medical records department at 404-255-4333 ext. 133 or in writing.
- I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.
- I may inspect or copy any information used or disclosed under this agreement.
- I have a right to receive a copy of this form.

Patient/Patient Representative:____________________________Date:_________

Printed Name:_______________________________Relationship:________________

METRO ATLANTA ENDOSCOPY
5669 Peachtree Dunwoody Rd.
Suite 210
404-255-4346