The Endoscopy Center of the South Bay

Office Hours 6:00 am - 4:00 pm

23560 Madison St., Suite #109
Torrance, CA 90505
Phone # (310) 325-6331
Fax # (310) 325-6335

Welcome to the Endoscopy Center of the South Bay. To help us ensure that your visit to our Center is as smooth as possible, please read the following information carefully.

1. The Endoscopy Center is considered an outpatient surgery center. Although we make every attempt to remain on schedule, please be aware that delays can occur. Due to the nature of any medical procedure, there are sometimes unforeseen circumstances that require additional time.
2. Our billing office staff will contact your insurance provider in order to verify your coverage. We recommend that you also contact your insurance provider so that you are familiar with your coverage and co-pay responsibilities prior to your procedure date. (if you have any questions, the billing office can be reached at 310-539-2059.)
3. Billing--You may incur up to 5 bills for your visit for the following services:
    - Physician services (South Bay Gastroenterology Medical Group)
    - Facility services (Endoscopy Center of the South Bay)
    - Anesthesia services (Endoscopy Center of the South Bay – Anesthesia)
    - Pathology (Torrance Pathology Associates, South Bay Gastroenterology Pathology or Quest Diagnostics) could incur (2)
4. For your safety, we require that you are accompanied home by a responsible adult after your procedure. The Center does not allow you to take a Taxi Cab. **You are not permitted to drive after your procedure for which you will be receiving anesthetic medications.**
5. If you need to cancel your appointment, this must be done 48 business hours prior to your procedure. If not, you will be charged a fee of $100.00.
6. Please be prepared to complete more paperwork at the Endoscopy Center. To allow for this, your arrival time is set one hour prior to the scheduled time of your procedure.
7. To improve your experience and eliminate discomfort, the center's anesthesia services will be provided by a board-certified, Certified Registered Nurse Anesthetist (CRNA).
8. The package you have received, includes the following: 1) Medication Restrictions 2) Procedure Preparation Instructions 3) Patient Medical History Forms 4) Notice of Patient Rights and Physician Ownership 5) Notice to Patients regarding Anesthesia Services and Fees if applicable 6) Notice regarding billing, coverage and benefits 7) Patient Consent to Resuscitative Measures Form (Advance Directive). Please complete all your forms prior to your arrival at the Endoscopy Center as these will expedite your check in process.
9. Translator – if you are unable to speak or read English, you must bring someone with you that can translate, so that we can effectively communicate instructions regarding the procedure.
10. A map to the Endoscopy Center is enclosed. **Please note that the Endoscopy Center is at a different location than the doctor's offices on Telo Avenue. The best way to enter our office is from Skypark Drive. We are at the North-East corner of Skypark and Madison.**

On the day of your procedure, please bring your:

- Drivers license or picture ID
- Insurance card(s)
- Medical history forms including list of current medications
- Phone number for person picking you up
- Glasses for reading, if necessary

If you have any questions or concerns either before or following your procedure, please feel free to call us either at the **Endoscopy Center (310) 325-6331** or at the doctors' offices at ***South Bay Gastroenterology Medical Group (310) 539-2055.***

Thank you,

The Endoscopy Center of the South Bay

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
The Endoscopy Center of the South Bay

Please check which provider you are seeing:

Susan M. Chan, M.D.
Jerome Cohen, M.D.
Tonny M. Lee, M.D.
Edward Piken, M.D.
Gloria Sze, M.D.
Oren Zaidel, M.D.
Wendy Ard, PA-C

PRACTICE LIMITED TO GASTROENTEROLOGY
23600 Telo Avenue, Suite 260
Torrance, California 90505
Telephone # (310) 539-2055
Southbaygastro.com

Endoscopy Center of the South Bay
23560 Madison Street, Suite 109
Torrance, California 90505
Telephone # (310) 325-6331

PATIENT INFORMATION

PATIENT NAME: _____ AGE _____ DATE OF BIRTH:_____

ADDRESS: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:_____ WORK: _____ CELL: _____

HOW DO YOU PREFER TO BE CONTACTED? HOME WORK CELL OR OTHER: _____

MARITAL STATUS: _____ GENDER:_____

EMAIL ADDRESS:_____

DO YOU RESIDE IN A SKILLED NURSING FACILITY: _____

FAMILY PHYSICIAN (REFERRING PHYSICIAN): _____ PHONE#_____

PHARMACY NAME: _____ADDRESS: _____ PHONE: _____

RACE: WHITE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER AMERICAN INDIAN-ALASKAN NATIVE OTHER

ETHNICITY: HISPANIC OR LATINO NON-HISPANIC OR LATINO Preferred Language: ENGLISH OTHER:_____

PRIMARY INSURANCE

COMPANY: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP: _____

MEMBER # _____GROUP # _____

NAME OF INSURED: _____INSURED SSN:_____

INSURED DATE OF BIRTH: _____RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE INFORMATION

COMPANY: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP: _____

MEMBER # _____GROUP # _____

NAME OF INSURED: _____INSURED SSN:_____

INSURED DATE OF BIRTH: _____RELATIONSHIP TO PATIENT:_____

EMPLOYMENT INFORMATION

EMPLOYER: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP_____

EMERGENCY NOTIFICATION

CONTACT:_____TELEPHONE: _____

RELATIONSHIP: _____

_____ _____

SIGNATURE OF PATIENT DATE

ENDOSCOPY CENTER OF THE SOUTH BAY

PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVE OR MEDICAL POWERS OF ATTORNEY

ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCE DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED ON THE PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THIS ENDOSCOPY CENTER RESPECTS AND UPHOLDS THOSE RIGHTS.

HOWEVER, UNLIKE IN AN ACUTE CARE HOSPITAL SETTING, THE ENDOSCOPY CENTER DOES NOT ROUTINELY PERFORM "HIGH RISK" PROCEDURES. MOST PROCEDURES PERFORMED IN THIS FACILITY ARE CONSIDERED TO BE OF MINIMAL RISK. OF COURSE, NO PROCEDURE IS WITHOUT RISK. YOU WILL DISCUSS THE SPECIFICS OF YOUR PROCEDURE WITH YOUR PHYSICIAN WHO CAN ANSWER YOUR QUESTIONS AS TO ITS RISKS, YOUR EXPECTED RECOVERY AND CARE AFTER YOUR PROCEDURE.

THEREFORE, WE RESPECT THE RIGHT OF PATIENTS TO MAKE INFORMED DECISIONS REGARDING THEIR CARE. IF A PATIENT BECOMES UNABLE TO MAKE A DECISION REGARDING HIS/HER OWN CARE, CENTER STAFF WILL CONSULT THE ADVANCE DIRECTIVES, MEDICAL POWER OF ATTORNEY, OR PATIENT REPRESENTATIVE OR SURROGATE, IF AVAILABLE. DUE TO THE OUTPATIENT NATURE OF AN AMBULATORY SURGERY CENTER, THIS CENTER HAS ADOPTED THE POSITION THAT AN AMBULATORY SURGERY CENTER SETTING IS NOT THE MOST APPROPRIATE SETTING FOR END OF LIFE DECISIONS. THEREFORE, IT IS THE POLICY OF THIS SURGERY CENTER THAT IN THE ABSENCE OF AN APPLICABLE PROPERLY EXECUTED ADVANCE DIRECTIVE, IF THERE IS A DETERIORATION IN THE PATIENT'S CONDITION DURING TREATMENT AT THE SURGERY CENTER, THE PERSONNEL AT THE CENTER WILL INITIATE RESUSCITATIVE OR OTHER STABILIZING MEASURES AND TRANSFER THE PATIENT TO AN ACUTE CARE HOSPITAL. AT THE ACUTE CARE HOSPITAL, FURTHER TREATMENT DECISIONS WILL BE MADE. IF COPIES OF THE PATIENT'S ADVANCE DIRECTIVES HAVE BEEN PROVIDED TO THE SURGERY CENTER, COPIES WILL BE SENT WITH THE PATIENT TO THE HOSPITAL.

IF THE PATIENT HAS ADVANCE DIRECTIVES WHICH HAVE BEEN PROVIDED TO THE SURGERY CENTER THAT IMPACT RESUSCITATIVE MEASURES BEING TAKEN, WE WILL DISCUSS THE TREATMENT PLAN WITH THE PATIENT AND HIS/HER PHYSICIAN TO DETERMINE THE APPROPRIATE COURSE OF ACTION TO BE TAKEN REGARDING THE PATIENT'S CARE.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

DO YOU HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR DURABLE POWER OF ATTORNEY ___ ***YES*** ___ ***NO***

DID YOU BRING A COPY WITH YOU TODAY? ___ ***YES*** ___ ***NO, IF NO WHERE IS IT LOCATED:*** _____

I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES ___ ***YES*** ___ ***NO***

THE ENDOSCOPY CENTER PROVIDED ME WITH A COPY OF THE CALIFORNIA STATE ADVANCE DIRECTIVE FORM ___ ***YES*** ___ ***NO***

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

BY: _____
(PATIENT'S SIGNATURE)

PATIENT'S LAST NAME: _____ PATIENT'S FIRST NAME: _____ DATE: _____

I ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.
BY: _____
(SIGNATURE)

_____
(PRINT NAME)

RELATIONSHIP TO PATIENT:

- COURT APPOINTED GUARDIAN
- ATTORNEY IN FACT
- HEALTH CARE SURROGATE
- OTHER _____

FOR OFFICE USE: COPY FILED IN CHART YES NO

STAFF SIGNATURE: _____

South Bay Gastroenterology Medical Group
And
The Endoscopy Center of the South Bay

Office Policy for Insurance Billing

South Bay Gastroenterology Medical Group and Endoscopy Center of the South Bay have enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plan, with different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employer's guidelines and stipulations; we must rely on you, the patient, to inform us regarding what those guidelines and stipulations are, at every visit.

Unfortunately, if you do not inform us of special requirements in your insurance contract regarding:

- **Lab work**
- **Screenings / Preventive Care**
- **Hospitalization and/or**
- **Out-Patient procedures**

that are non-covered, need a referral from your primary care physician or need to be performed at a specified location; we have no choice but to bill you directly for those charges. Payments for those charges will then be your responsibility.

Please check with your insurance if you have any questions related to the services we provide. We would like to ensure that you receive all the benefits offered to you.

****

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signature:_____ Date: _____

Anthem BlueCross

ANTHEM BLUE CROSS
COVERED INDIVIDUAL (PATIENT) RESPONSIBILITY AGREEMENT – WAIVER LETTER

Contracting Anthem Blue Cross health care professionals/facilities ("Providers") are prohibited from charging Anthem Blue Cross Covered Individuals for any service or supply that is determined by Anthem Blue Cross to be not Medically Necessary, unless the Covered Individuals specifically agrees in advance of the provision of the service or supply to be financially responsible for payment with specific knowledge of Anthem Blue Cross' determination that the service or supply was determined to be not Medically Necessary. This Waiver Letter shall be used by the Provider in such instances and must be separate from any patient payment responsibility information in the hospital admission form. To be effective and valid, this Waiver Letter must be executed prior to the delivery of any service or supply that was determined to be not Medically Necessary.

COVERED INDIVIDUAL (PATIENT) NAME:_____ **DOB:** _____

SUBSCRIBER ID:_____ **GROUP NO.:** _____

PROVIDER: Endoscopy Center of the South Bay

PROVIDER NPI/TAXID:_____

PROVIDER PHONE: 310-325-6331

COVERED INDIVIDUAL:
By signing below, I agree to pay Provider for those services or supplies that Anthem Blue Cross determined were not Medically Necessary.

I understand that a Provider may not charge me for a service or supply determined to be not medically necessary unless I have specifically agreed to pay for it in advance and with specific knowledge of Anthem Blue Cross' determination that the services were determined to be not medically necessary. I also understand that the Provider and/or I may appeal any determination that a service or supply is not Medically Necessary by filing a grievance or appeal with Anthem Blue Cross or the Department of Managed Health Care ("DMHC:) pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the services and/or supplies listed below, I understand that I am financially responsible for payment to the Provider, even though they may not be shown on my Explanation of Benefits (EOB) as my financial responsibility.

Date(s) of Service	Description of Service and/or supply	Approximate Cost	Covered Individual's (Patient's) Responsibility
	Colonoscopy	$175.00	$175.00
	Endoscopy	$175.00	$175.00
	Colonoscopy and Endoscopy	$225.00	$225.00

* The above only applies to anesthesia charges.

Signature:_____ Date: _____

Covered Individual/ Subscriber Signature

PROVIDER:
Provider please send a completed copy of this waiver form with the initial claim to the claims address on the Covered Individual (Patient's) identification card for appropriate claims processing. This does not represent a renegotiation of an already negotiated rate between Provider and Anthem Blue Cross.

rev. 5/2014
POS® Reorder # 1412702

blue of california

Member Acknowledgement of Financial Responsibility

Provider, please check one of the following:

Blue Shield has indicated that the services listed are not covered under your benefit plan.

☑ Your benefits have not been verified. In the event that Blue Shield determines that the services listed are not covered under your benefit plan, you will be responsible for the cost of that service.

Provider: This form must be used for Blue Shield members who wish to receive healthcare services from you that may not be covered by their Blue Shield Benefit Plan. Acknowledgement of responsibility must include specific information regarding date of service, services provided, and billed amounts.

Member: Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your Blue Shield Benefit Plan, or,
- The services have not been otherwise approved for payment by Blue Shield.

Service Description:

(Any service not described as a covered benefit in the member's *Evidence of Coverage*.)

Anesthesia services for colonoscopy or upper endoscopy = $175.00

Anesthesia services for colonoscopy and upper endoscopy (both) = $225.00

Date of Service:

Billed Amount: $175.00 / $225.00

Member or Member's Legal Representative Name (Please Print)

Member or Member's Legal Representative Signature Date

Provider or Provider's Representative Name (Please Print)

Provider or Provider's Representative Signature Date

QUESTIONS?

For HMO providers, please contact Blue Shield Member Services at **(800) 424-6521**.
For PPO providers, please contact the Blue Shield Provider Services Liaison Unit at **(800) 258-3091**.

Endoscopy Center of the South Bay
23560 Madison Street, Suite 109
Torrance, California 90505

ADVANCED NOTICE TO PATIENTS

Please read, initial where indicated and sign below

Endoscopy Center of the South Bay is now offering anesthesia services to its patients. Propofol is an IV drug administered by a Certified Registered Nurse Anesthetist (CRNA), who is trained to administer your sedation. Please note that charges for anesthetic services (CRNA) are separate from and in addition to routine charges for endoscopic services rendered by your physician, the surgery center, and pathology charges (biopsies, if taken). These charges are generally covered by your health insurance policy.

_____ **(INITIAL HERE)** I understand that following my receipt of the professional services referred to above, I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance that may be applicable.

Non coverage or anesthesia for services provided

_____ **(INITIAL HERE)** I am aware that my insurance company may not pay/cover this service and I acknowledge that I will be billed the following amount if my insurance company denies payment for any reason:

_____ $175.00 (anesthesia services for colonoscopy or upper endoscopy)

_____ $225.00 (anesthesia services for colonoscopy and upper endoscopy)

_____ _____

Patient Signature Date

_____

Print Name

ENDOSCOPY CENTER OF THE SOUTH BAY

Please review the following information, regarding billing practices and changes to coverage and benefits

As a courtesy, we verify coverage and benefits a few days prior to scheduled procedures. We attempt to contact patients to inform them of out of pocket expenses that are in excess of $500.00 which they are responsible for. If during the verification process, we are informed by the patients' insurance company that the procedure will not be covered, we make an effort to notify the patient in advance. **IT IS ULTIMATELY THE PATIENT'S RESPONSIBILITY TO VERIFY AND BE INFORMED ABOUT THEIR COVERAGE AND BENEFITS.** The information given to us by any insurance company is a benefit quote limited to the information they have on file at the time of the inquiry and is not guaranteed.

OUR BILLING PROCESS IS AS FOLLOWS:

You may incur up to five *(5) charges for your procedure. The doctor will charge for his/her professional fee which is billed under *South Bay Gastroenterology* and the facility will charge for the use of the ambulatory surgical center which is billed under *The Endoscopy Center of the South Bay*. Anesthesia will be charged separately and will be billed to your insurance company/companies. *If a biopsy or removal is performed you will incur (2) additional bills for pathology. Once your insurance company/companies has processed and made payment, any remaining balance, which is "Patient Responsibility", will be billed on 4 separate statements as described above. Payments should be made to each entity separately.

COLONOSCOPY SCREENING:

If you are scheduled for a colonoscopy, please acknowledge the following:

The reason for a screening exam is for the detection of any abnormalities. IF ANYTHING IS FOUND AND REQUIRES INTERVENTION (FOR EXAMPLE A POLYP IS FOUND AND A BIOPSY IS TAKEN) THE EXAM IS NO LONGER CONSIDERED A SCREENING AND YOUR BENEFITS MAY CHANGE. In accordance with billing and coding guidelines, we must report the findings (reason for the intervention) as the primary diagnosis and the screening code as the subsequent diagnosis. It is important to understand the difference between a screening and a diagnostic colonoscopy. A screening colonoscopy is performed on patients who do not have signs or symptoms and there are no significant findings found during the examination. A diagnostic colonoscopy is performed to evaluate signs or symptoms of disease.

If you have any questions regarding this notice, please feel free to address them with the Billing Department at 310-539-2055.

For questions regarding your benefits, please contact your insurance company.

I have read and understand the information above.

Patient Name: _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Endoscopy Center of the South Bay - 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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice main or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliances with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
☐ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
You have the right to request that we amend your information.
You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Elaine Campos, RN (310) 325-6331

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

_____ Date: _____

ENDOSCOPY CENTER OF THE SOUTH BAY

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Endoscopy Center of the South Bay, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Endoscopy Center of the South Bay may have an ownership interest in Endoscopy Center of the South Bay. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Endoscopy Center of the South Bay.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Endoscopy Center of the South Bay policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advanced Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____

Signature of Patient or Responsible Party **Print Name**

_____ _____

Relationship to Patient **Date Signed**

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
AND
The Endoscopy Center of the South Bay - Patient History Form *pg 1 of 2*

[PATIENT LABEL]

Patient's Name: _____

Date of Birth: _____

Occupation: _____

Marital Status: Married Divorced Single Widowed

Age _____ Weight _____ lbs Height_____ft _____inches

Reason for Visit: Rectal bleeding Anemia
Family History Re-Check Change in Bowel Habits
Abdominal Pain Other: _____
_____
_____

History: **Relation:**

Cancer *(type)* _____
Polyps *(colon/stomach)* _____
Ulcers _____
Liver Disease _____
Pancreatitis _____

Family History

	If Living		If Deceased	
	Age	Health	Age	Cause
Father				
Mother				
Brother/Sister				
Other Blood Relatives				
Son/Daughter				

Do you smoke? Yes No
packages per day _____
of years smoked _____

Do you use alcohol? Yes No
drinks per day _____

Illnesses/Surgeries: PLEASE PROVIDE DATES
(If none, please indicate with N/A)
1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a Colonoscopy or an Upper Endoscopy before? Yes No When? _____
Results: _____

Medications: List all Medications, Dosage & Frequency. (This should include: All Prescription, Herbal and over the counter Medications) If not applicable, please indicate with N/A. If necessary please use the back of this form or attach a list.

DRUG NAME DOSAGE HOW OFTEN
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Herbals, Vitamins, Supplements & Non - Prescriptive Drugs:
1. _____
2. _____
3. _____

Allergies: Include Medication, Foods and Latex. Please note reactions. ***(If not applicable indicate with N/A)***
No Known Allergies
LATEX ALLERGY? YES No Reaction; _____
_____

DRUG ALLERGIES TYPE of REACTION
1. _____
2. _____
3. _____
4. _____
5. _____

FOOD ALLERGIES TYPE of REACTION
1. _____
2. _____
3. _____

[PATIENT LABEL]

Patient Name: _____

Cardiovascular

Heart Murmur	Yes	No
Heart Valve Replacement	Yes	No
Chest Pain	Yes	No
Heart Attacks	Yes	No
If yes, please provide dates: _____		
Heart Stents	Yes	No
If yes please provide dates: _____		
_____		
High Blood Pressure	Yes	No
Defibrillator / Pacemaker	Yes	No
AICD/ *CRMD	Yes	No
**Cardiac Rhythm Management Device*		
High Cholesterol	Yes	No
Heart Surgery	Yes	No
Swelling of Ankles	Yes	No
Cardiomyopathy or Congestive Heart Failure	Yes	No

Constitutional

Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No

Endocrine

Heat or Cold Intolerance	Yes	No
Excessive Thirst or Urination	Yes	No
Diabetes TYPE 1 or TYPE 2	Yes	No
Thyroid Trouble	Yes	No

Eyes/Skin/ENT

Blurred and double vision	Yes	No
Glaucoma	Yes	No
Rash / Itching	Yes	No
Jaundice	Yes	No
Hearing Loss / Ringing In Ears	Yes	No
Mouth Sores	Yes	No
Nosebleeds	Yes	No

Gastrointestinal

Poor Appetite	Yes	No
Difficulty in Swallowing	Yes	No
Heartburn and Indigestion	Yes	No
Nausea or Vomiting	Yes	No
Bloating / Belching	Yes	No
Regurgitation	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Abdominal Pain	Yes	No
Recent Change In Bowel Habits	Yes	No
Rectal Bleeding	Yes	No
Black, Tarry Stools	Yes	No
Gallbladder Disease	Yes	No
Liver Trouble	Yes	No
Hemorrhoids	Yes	No
Hiatal Hernia	Yes	No

Musculoskeletal

Joint Pain or Swelling	Yes	No
Back Pain / Muscle Pain	Yes	No

Genitourinary

Burning w/Urination	Yes	No
Blood in Urine	Yes	No
Kidney Trouble	Yes	No

Hematological

Bleeding/Bruising Tendency	Yes	No
Anemia	Yes	No
Blood Transfusion	Yes	No

Respiratory

Chronic Cough	Yes	No
Spitting up Blood	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No
Do you use Oxygen?	Yes	No
COPD	Yes	No
Obstructive Sleep Apnea	Yes	No
Do you use a CPAP Machine	Yes	No

Infectious Disease

Hepatitis	Yes	No
Type: _____		
AIDS	Yes	No
HIV	Yes	No
Do you currently have any condition that has been deemed		
Infectious / communicable	Yes	No
If yes explain: _____		
Other: _____		

Psychiatric

Memory Loss/Confusion	Yes	No
Depression	Yes	No
Panic Attacks/Anxiety Disorder	Yes	No

Neurological

Dementia	Yes	No
Alzheimer's	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Strokes	Yes	No
Difficulty laying on Left Side	Yes	No
Numbness	Yes	No
If yes, where? _____		
Weakness (Left or Right)	Yes	No

Are you Pregnant? Yes No

Is there anything else we should know regarding your medical history? *(Please use an additional sheet if necessary)*

_____

Who is your referring Doctor?: _____

Phone No: _____ **Fax No.:** _____

Who is your Primary Doctor?: _____

Phone No: _____ **Fax No.:** _____

Address: _____

_____

Do you have a Cardiologist? No Yes Please provide:

Name: _____

Phone #: _____

Patient Signature: _____

Date: _____

Physician's Signature: _____

Date: _____

C.R.N.A's Signature: _____

Date: _____

Patient Rights and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- To ensure that the rights and responsibilities of patients are communicated and respected throughout the patient's care experience at the surgery center.
- Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
- To be treated with respect, consideration, and dignity.
- To be provided with appropriate personal privacy, care in a safe setting and freedom from all forms of abuse and harassment.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other healthcare providers who will see him/her.
- Receive information from his/her physician about your illness, his/her course of treatment and the prospects of recovery in a manner that will be understood by the patient and/or patient representative/surrogate.
- Receive as much information from your physician about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies this information shall include a description of the procedure or treatment, the medically significant risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
- Actively participate in decisions regarding his/her medical care to the extent permitted by law; this includes the right to refuse treatment or change his/her primary physician.
- Disclosures and records are treated confidentially, except when required by law, patients are given the opportunity to approve or refuse their release.
- Information for the provisions of after-hour and emergency care.
- Information regarding fees for service, payment policies and financial obligations.
- The right to decline participation in experimental or trial studies.
- The right to receive marketing or advertising materials that reflect the services of the center in a way which is not misleading.
- The right to express concerns and receive a response to inquiries in a timely fashion.
- The right to self-determination including the right to accept or to refuse treatment and the right to formulate an Advance Healthcare Directive and understand the facility's policy and state regulations regarding Advance Healthcare Directives.
- The right to know and understand what to expect related to their care and treatment.
- Access protective and advocacy services or have these services assessed on the patient's behalf.
- 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.
- Be advised of the facility's grievance process, should the patient or patient's representative or surrogate wish to communicate a concern regarding the quality of the care he or she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- To leave the facility even against the advice of his/her physician.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his/her patient record.
- To appropriate assessment and management of pain.
- Be advised if the physician has a financial interest in the surgery center.

PATIENT RESPONSIBILITIES:

- Provide complete and accurate information to the best of your ability regarding your health, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Ask for an explanation if you do not understand papers you are asked to sign or anything about your own care.
- Gather as much information as you need to make informed decisions.
- Follow the care prescribed or recommended for you by the physicians, nurses, and other members of the health care team.
- Respect the rights and privacy of others.
- Assure the financial obligations associated with your own or is fulfilled.
- Take an active role in ensuring safe patient care. Ask questions or state concerns while in our care. If you don't understand, ask again.
- Provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
- Inform the center and physician about any Advance Directives that could affect your care.
- Keep appointments and notify the physician or facility when unable to do so.

If you need an interpreter: If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment.

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. California laws regarding Advanced Directives are found in the California Probate Code Section 4670 to 4678 and 4700 to 4701. There are two types of Advance Directives: Power of Attorney for Healthcare and Instructions for Healthcare. You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative) prior to the procedure being performed.

The ENDOSCOPY CENTER of the SOUTH BAY respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

CENTER CONTACT INFORMATION:
Elaine Campos RN – Center Director
ENDOSCOPY CENTER OF THE SOUTH BAY
23560 Madison Street, Suite 109
Torrance, CA 90505
STATE OF CALIFORNIA CONTACT INFORMATION:
The Medical Board of California
Central Complaints Unit
2005 Evergreen Street Suite 1200
Sacramento, CA 95815
PHONE NUMBER: 916-263-2382 or 1-800-633-2322
TDD: 916-263-0935
FAX: 916-263-2944
State Web site: http://www.mbc.ca.gov
Local Department of Health Services:
313 N. Figueroa Street,
Los Angeles, CA 90012
1-877-333-4952
MEDICARE:
Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.
Medicare Ombudsman Web site: www.medicare.gov/Ombudsman/resources.asp
Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)
Office of the Inspector General: http://oig.hhs.gov
This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077 Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

Physician Financial Interest and Ownership: The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:

Dr. Edward Piken, Dr. Jerome Cohen, Dr. Gloria Sze, Dr. Tonny Lee and Dr. Oren Zaidel