Endoscopy Center of the South Bay

23560 Madison St., Suite 109, Torrance, CA 90505
310-325-6331
(Office hours 6:00am – 4:00pm)

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 receive 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 (2) (Torrance Pathology Associates, South Bay Gastroenterology Pathology or Quest Diagnostics)
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 for 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

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 DIRECTVES, 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 TRANSER THE PATIENT TO AN ACUTE CARE HOSPITAL. AT THE ACUTE CARE HOSPITAL, FURTHER TREATAMENT 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 PYSICIAN 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: ____

REV 09/2013

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 insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plan having 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 such as:

- Lab work
- Screenings / Preventative 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 7/2013

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 o 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 anesthesia 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 of anesthesia for services provided

_________(**INITIAL HERE)** I am aware that my insurance company my 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 KNOW 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 payments, 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 mail 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 compliance 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 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:

Center Leader (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 Advance 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 full accepts all terms specified above.

____	________________________________
Signature of Patient or Responsible Party	**Print Name**
____	________________________________
Relationship to Patient	**Date Signed**

Last Reviewed: 8/30/2013

SOUTH BAY GASTROENTEROLOGY
MEDICAL GROUP
AND
Endoscopy center of the South Bay ***Patient History Form***

[patient label]

Patient Name_________________________________

Birthday: ______________________________

Occupation: ____________________________

Marital Status:
☐Married ☐Divorced ☐ Single ☐Widowed

Age _______ Weight ___________ Height ___________

Reason for Visit: ☐Rectal bleeding ☐ Screening ☐ Anemia

☐Family History ☐Re-Check ☐ Chg in Bowel Habits☐Abd Pain
Other:____
____
____

History: **Relation**:

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

Family History	**If Living** Age	Health	**If Deceased** 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:
(if none applicable please indicate with N/A)
____
____
____
____
____

Medications: ***List all Medications, Dosage, Frequency and When last taken (this should include all prescription, Herbal and over the counter Medications) If none Applicable please indicate with N/A***
(if necessary please use the back of this form or attach a list)
____
____
____
____
____
____
____

Allergies: Include Medication, Foods and Latex. Please note reactions. *(if not applicable indicate with N/A)*
____
____
____

Have you ever had a Colonoscopy or Esophagogastroduodenoscopy (upper Endoscopy) before?
☐ Yes ☐ No
When _________________
Results ____
____

Who is your referring Doctor : _____________________

Who is your Primary Doctor: _____________________

Address: ____________________________________
____

Phone: ________________________

Fax No.: ________________________

Cardiologist Name: ______________________________
Phone : ______________________________
Fax No.:______________________________
____

Patient Signature: ______________________________

Date: ____________________

PATIENT HISTORY FORM

[Patient Label]

Patient Name:_______________________________

Cardiovascular
Heart Valve Replacement ☐Yes ☐No
Chest Pain ☐Yes ☐No
Swelling of Ankles ☐Yes ☐No
Heart Attacks ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Defibrillator / Pacemaker ☐Yes ☐No
AICD/ *CRMD ☐Yes ☐No
**Cardiac Rhythm Management Device*
High Cholesterol ☐Yes ☐No
Heart Surgery ☐Yes ☐No
Heart Stents ☐Yes ☐No
If yes please explain:

____

____

Constitutional
Recent weight change ☐Yes ☐No
Fever ☐Yes ☐No
Fatigue ☐Yes ☐No

Diabetes
What Type? ________________________
Fasting Blood Sugar __________Time________
Thyroid Trouble ☐Yes ☐No

Endocrine
Heat or Cold Intolerance ☐Yes ☐No
Excessive Thirst or Urination ☐Yes ☐No

Eyes/Skin/ENT
Blurred and double vision ☐Yes ☐No
Glaucoma ☐Yes ☐No
Rash / Itching ☐Yes ☐No
Jaundice ☐Yes ☐No
Hearing Loss ☐Yes ☐No
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 ☐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: (use back if necessary)

____

____

Reviewed By M.D.
Date: __________ Doctor: __________________

Date: __________ Doctor: __________________

Endoscopy Center Use Only:
Admitting Nurse: ___________________ Date:_________
CRNA:______________________________Date:_________
*Proc. Rm Nurse: ___________________Date:_________
*only used if Conscious Sedation was used
Nursing Comments:

____

____

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 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 / Facility Policy

You have the right to information on the center's policy regarding Advance Directives.

Advance Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures, in accordance with advance directives, can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

An "advance health care directive" lets your physician, family and friends know your health care preferences, including the types of special treatment you want or don't want at the end of life, your desire for diagnostic testing, surgical procedures, cardiopulmonary resuscitation and organ donation.

If you request, an official state Advance Directive Form will be provided to you.

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:

Elaine Campos—CENTER DIRECTOR
23560 Madison Street, Suite 114
Torrance, CA 90505
(310) 325-6331

For complaints regarding a physician or facility, contact:

Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Or:

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847) 853-6060

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

Sites for address and phone numbers of regulatory agencies: **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
Physician Financial Interest and Ownership: 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 informed regarding such interest and to be treated at another health care facility if they so desire. *(A list of physician owners or those with financial interest in the Center will be provided upon request.)* We are making this disclosure in accordance with federal regulations.

Last Reviewed: 1/12/2011

Patient's Rights and Notification of Physician Ownership

Endoscopy Center of the South Bay
23560 Madison Street, Suite 114
Torrance, CA 90505
(310) 325-6331

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

Signature of Patient or Patient Legal Representative

Date ____________

AS A PATIENT OF THE **ENDOSCOPY CENTER OF THE SOUTH BAY**, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF YOUR PROCEDURE

PATIENT'S BILL OF RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

PATIENT'S RIGHTS:

To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery, and/or services.

To be provided privacy and security of self and belongings during the delivery of patient care service.

To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

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.

To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the mecical record

To be free from mental and physical abuse, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

To leave the facility even against the advice of his/her physician

Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care

Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility

To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

To know which facility rules and policies apply to his/her conduct while a patient

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 right

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 examine and receive an explanation of his/her bill regardless of source of payment

To appropriate assessment and management of pain

PATIENT'S RESPONSIBILITIES

To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities

To follow the treatment plan prescribed by their provider

To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider

To inform their provider about any living will, mecical power of attorney, or other directive that could affect their care

To accept personal financial responsibility for any charges not covered by their insurance

To be respectful of all the health care providers and staff, as well as other patients

If you need an interpreter:

If you will need an interpreter, **please let us know prior to the day of your procedure,** 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.