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.
- ☐ Daniel D. Cho, M.D.
- ☐ Gloria Sze, M.D.
- ☐ Oren Zaidel M.D.
- ☐ Minh Q. Nguyen, M.D.
- ☐ Wendy Ard, PA-C
- ☐ Mary Anmadian, NP

PRACTICE LIMITED TO GASTROENTEROLOGY
23456 Hawthorne Blvd #300
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 _____

RELATION TO PATIENT: _____

EMERGENCY NOTIFICATION

CONTACT: _____ TELEPHONE: _____

RELATIONSHIP: _____

_____ _____

SIGNATURE OF PATIENT DATE

ENDOSCOPY CENTER OF THE SOUTHBAY
PATIENT CONSENT TO RESUSCITATIVE MEASURES

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.

Facility Policy

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.

I have an Advance Directive or Living Will? _____**Yes** _____**No**

I have brought a copy of my Advance Directive or Living Will? _____**Yes** _____**No**

If no, where is it located: _____

Would you like information on Advance Directives? _____**Yes** _____**No**

Patient Signature_____ **Date:** _____

Office use: copy filed in chart ☐ Yes ☐ No

Staff signature:_____

Revised 08/2014

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.

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
Anesthesia Billing Phone
#866-809-1220

NOTICE TO PATIENTS REGARDING ANESTHESIA BILLING

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. As to Anesthesia, we are unable to get prior authorization. Our CRNA's may be out of your network. If you would like to check, please feel free in contacting our billing department at 866-809-1220.

_____ **(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 and/or Cash prices for Anesthesia 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: _____

ENDOSCOPY CENTER OF THE SOUTH BAY - NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.

How We Use & Disclose Your PHI

Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care.

Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan.

Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it.

The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.

Other Uses and Disclosures We May Make

Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care.

Required by Law: We may disclose your PHI as required by law , such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law.

Research: We may use or disclose PHI for approved medical research.

Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises.

Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose PHI 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 PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes.

Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

De-identification. We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential.

Health information exchanges. We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.

In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.

If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.

We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with drafting notes or scheduling appointments.

Individual Rights

You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.

□ 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.

□ You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.

□ You have the right to request that we amend your PHI.

□ You may request a list of disclosures of PHI about you except for disclosures made with your authorization and 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 Duties/Changes to this Notice

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, 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 PHI.

We may change this Notice at any time and make the new terms effective for all PHI 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 Contact Person listed below.

Complaints/Contact Person

If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:

Center Privacy Officer (310-325-6331)

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**

Last Reviewed: 8/30/2013

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

[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 HISTORY FORM

[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's 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.
- To be informed of their right to change providers if other qualified providers are available.
- Receive information from his/her physician about your illness, his/her course of treatment and the prospects for 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 provision 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 accessed 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.
- (IF APPLICABLE) Be advised as to the absence of malpractice coverage.
- (IF APPLICABLE) Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and for the participation of the caregiver in decisions affecting medical treatment.

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 or your child's care.
- Gather as much information as you need to make informed decisions.
- Follow the care prescribed or recommended for you or your child 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 your child's care 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.
- To be respectful of all the healthcare professionals and staff, as well as other patients.
- In the case of pediatric patients, a parent or guardian is responsible to remain in the facility for the duration of the patient's stay in the facility. The parent or legal guardian is responsible for participating in decision making regarding the patient's care.

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.

PATIENT RIGHTS Brochure

Endoscopy Center of the South Bay

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

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 DIRECTOR
23560 Madison Street, Suite 109
Torrance, CA 90505
310.325.6331

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
TDD: 916-263-0935
FAX: 916-263-2435
State Web site: http://www.medbd.ca.gov/complaints.html

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
(847) 853-6060 or email: info@aaahc.org

revised 03/2015

PATIENT RIGHTS Brochure

Endoscopy Center of the South Bay

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.

Endoscopy Center of the South Bay respects the right of the 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 our 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 physicians to determine the appropriate course of action to be taken regarding the patient's care.

Physician Ownership

Physicians Financial Interest and Ownership: The center is owned, in part, by 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 the disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:

- Dr. Jerome Cohen
- Dr. Gloria Sze
- Dr. Minh Nguyen
- Dr. Tonny Lee
- Dr. Oren Zaidel

Endoscopy Center of the South Bay
23560 Madison Avenue, Suite 109
Torrance, CA 90505
(310.325.6331

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