Leo E. Eickhoff, MD
P.K. Dhanuka, MD
B Nicholas Namihas, MD
Hongguang Liu, MD
Prathibha Chandrasekaran, MD

GENERAL INSTRUCTIONS

You have been scheduled for a procedure at Redding Endoscopy Center. Enclosed is your paperwork for the Center. Please complete and bring with you on the day of your procedure appointment. Listed below are some instructions about the paperwork.

PLEASE READ ALL PAPERWORK

Please bring completed paperwork with you, and plan to stay **1 ½ - 2 hours.**
Sometimes patient flow may make your stay longer.

Please bring your insurance cards, a picture ID, co-pay/deductible, glasses/hearing aids, and make sure you have **completed** your Medication Reconciliation (list of your medications), form. We will **NO longer accept** a separate medication list, hand written or typed.

Please make sure you have someone who can take you home.
Your ride is welcome to leave the Center during your procedure, but they must be reachable via cell phone while you are in the procedure room and afterwards in the recovery room. You will be ready to go home 30 minutes after your procedure has finished.

Cell Phones & Electronic Devices are not allowed in the surgery area. We are also **NOT** responsible for your lost or stolen articles.

If you need to reschedule your procedure, please do so at least **72 hours in advance**.

To cancel or reschedule a procedure, please **call us at 530-246-7000**.

As a Medicare certified facility we have the duty to inform you of certain information prior to the date of your procedure. This information is contained in the "Patient Forms" section on our website, www.reddingendoscopy.com. Please click on the heading "For Your Visit" and the link "Patient Forms." This document will be entitled *Patient Right's & Physician Notification of Ownership*. A copy is also attached with this packet.

We look forward to seeing you.

If you have any questions; please call (530) 246-7000.

Thank you.

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Procedure Center:
2179 Court St
Redding, CA 96001
P: (530) 246-7000
F: (530) 319-3256

Physician's Office:
1825 Sonoma St
Redding, CA 96001
P: (530) 243-8667
F: (530) 243-8742

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST—FIRST—MIDDLE INITIAL)	ADDRESS

CITY, STATE	ZIP	EMAIL ADDRESS	WOULD YOU LIKE TO BE WEB ENABLED ☐ YES ☐ NO

HOME PHONE	CELL PHONE	MAY WE LEAVE A MESSAGE ☐ YES ☐ NO	CAN WE DISCUSS RESULTS WITH ANYONE ELSE? ☐ YES ☐ NO WHO:

NAME OF PERSON DRIVING YOU HOME FROM YOUR PROCEDURE?	PHONE NUMBER OF YOUR DRIVER:	CAN WE DISCUSS RESULTS WITH DRIVER? ☐ YES ☐ NO

PATIENT DOB:	AGE	SEX ☐ MALE ☐ FEMALE ☐ OTHER:	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT HEIGHT ' "	PATIENT WEIGHT LBS.	RACE:	ETHNICITY:	PATIENT PREFERRED LANGUAGE	ADVANCE DIRECTIVE? ☐ YES ☐ NO

PREFERRED PHARMACY	LOCATION	PATIENT SSN

DO YOU SMOKE	DO YOU DRINK ALCOHOL	DO YOU USE ANY RECREATIONAL DRUGS?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
# OF CIGARETTES/PACKS PER DAY: ____________	WHAT TYPE: ______________________________________	WHAT TYPE: __________________________
# OF YEARS SMOKED: __________________	# OF DRINKS PER WEEK:___________________________	

HEALTH & PHYSICAL INFORTMATION

CHIEF COMPLAINT:	REASON FOR TODAY'S VISIT: ☐ OFFICE VISIT ☐ PAPERWORK PICKUP FOR ONE OF THE FOLLOWING: UPPER ENDOSCOPY (EGD), COLONOSCOPY, FLEXIBLE SIGMOIDOSCOPY

PAST MEDICAL HISTORY: ***(LIST YOUR CHRONIC MEDICAL PROBLEMS SUCH AS HIGH BLOOD PRESSURE OR DIABETES- INCLUDE DATES DIAGNOSED)***

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

5.______________________________ 6.______________________________

7.______________________________ 8.______________________________

PRIOR SURGERIES/ PROCEDURES ***(INCLUDE ANY CONLONSCOPIES, EGD's, RECALL, OCCULT BLOOD TESTS, ABDOMINAL X-RAY, FLEXIBLE SIGMOIDOSCOPIES, AND DATES DONE)***

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

5.______________________________ 6.______________________________

7.______________________________ 8.______________________________

CARDIOLOGIST: ***PLEASE BRING YOUR PACEMAKER CARD TO YOUR PROCEDURE APPOINTMENT***

DO YOU SEE A CARDIOLOGIST ☐ YES ☐ NO	CARDIOLOGIST NAME	DATE OF LAST VISIT / /	DO YOU TAKE A BLOOD THINNER? ☐ YES ☐ NO NAME:

CARDIAC SURGERIES ☐ ☐	STENT PLACEMENT:

ARE YOU CURRENTLY ON DIALYSIS YES NO	NAME OF DIALYSIS CENTER

LAST NAME:	FIRST NAME:	DOB:

FAMILY HISTORY *(CHECK MARK IF APPLICABLE)*

	GRANDFATHER	GRANDMOTHER	FATHER	MOTHER	SIBLINGS	IF CHECKED YES - LIST AT WHAT AGE:
DECEASED						
CANCER *(TYPE?)* →						
COLON POLYPS						
ULCER						
PANCREATITIS						
LIVER DISEASE						
ULCERATIVE COLITIS						
CROHN'S DISEASE						

REVIEW OF SYSTEMS

(ONLY CHECK THE BOX IF IT APPLIES TO YOU)

CARDIOVASCULAR:	YES
HYPERTENSION	
CHEST PAIN	
MYOCARDIAL INFARCTION (MI)	
CORONARY ARTERY DISEASE (CAD)	
HEART MURMUR	
ARRHYTHMIA (IRREGULAR HEARTBEAT)/PALPITATIONS	
PACEMAKER/DEFIBRILLATOR	
CORONARY STENTS	
SHORTNESS OF BREATH	
ENDOCRINE:	
DIABETES- I OR II *(CIRCLE WHICH ONE APPLIES)*	
THYROID DISEASE	
HEMATOLOGICAL:	
ANEMIA	
RECENT BLOOD TRANSFUSION	
ABNORMAL BRUISES	
RESPIRATORY:	
ASTHMA/WHEEZING	
COPD/EMPHYSEMA	
TUBERCULOSIS	
SLEEP APNEA/CPAP/BI-PAP (CIRCLE WHICH ONE YOU USE)	
CHRONIC COUGH	
USE OF HOME OXYGEN	
MUSCULOSKELETAL:	
JOINT PAIN/ARTHRITIS	
SWELLING	
PAIN IN CALVES	
SKIN:	
RASH	
GENITOURINARY:	
BURNING WITH URINATION	
BLOOD IN URINE	
KIDNEY DISEASE	
MISCELLANOUS:	
PROSTHETICS *(METAL RODS/HARDWARE)*	
MRSA	
CDIFF	
INFECTIONS *(HEPATITIS, ETC)*	

GENERAL/CONSTITUTIONAL	YES
UNEXPLAINED WEIGHT LOSS	
FEVER/CHILLS	
FATIGUE	
EYES:	
BLURRED VISION	
GLAUCOMA	
EARS/NOSE/MOUTH/THROAT:	
HEARING LOSS	
RINGING IN EARS	
MOUTH SORES	
NEUROLOGICAL:	
STROKE	
DIZZINESS	
SEIZURES	
HEADACHES	
MIGRAINES	
GASTROINTESTINAL:	
CONSTIPATION	
REFLUX/HEARTBURN	
ULCER	
DIARRHEA	
VOMITING OF BLOOD	
TROUBLE SWALLOWING	
FULLNESS IN STOMACH/BLOATING	
LOSS OF APPETITE	
NAUSEA OR VOMITING	
ABDOMINAL PAIN	
BLACK OR TARRY STOOLS	
RECTAL BLEEDING	
CHANGE IN BOWEL HABITS	
PSYCHIATRIC:	
MEMORY LOSS OR CONFUSION	
DEPRESSION	
OBGYN:	
ARE YOU PREGNANT	
DATE OF LAST MENSTRUAL CYCLE	
HEAVY MENSTRUAL CYCLES	
ENDOMETRIOSIS	

LAST NAME:	FIRST NAME	DOB:

ALLERGIES

DO YOU HAVE ALLERGIES: ☐ YES ☐ NO	LATEX ALLERGY: ☐ YES ☐ NO

ALLERGY (DRUG)	REACTION

CURRENT PRESCRIPTION MEDICATIONS

NAME OF PRESCRIPTION MEDICATION- *(FILL OUT LAST DATE TAKEN, ON DAY OF PROCEDURE)*	DOSE	FREQUENCY	LAST DATE TAKEN
HERBALS/VITAMINS/SUPPLEMENTS/ NON-PRESCRIPTION DRUGS:	**DOSE**	**FREQUENCY**	**LAST DATE TAKEN**

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information to be covered by this authorization includes, Printed, digital and verbal protected health information. Persons who can use this information: Leo Eickhoff MD, Inc (Redding Gastroenterology), Redding Endoscopy Center, DOCS Medical Group Inc. and their associates and staff.

Persons we are authorized to disclose information to other than the above listed are:

Name of Person or persons allowed access to records	Relationship to patient
____	______________________________
____	______________________________

This authorization will remain in effect until ____/____/____ or one year from signature date, unless otherwise revoked or terminated by the patient of the patient's guardian or representative.

You may revoke or terminate this authorization by submitting in writing to Redding Gastroenterology or by contacting the office manager or records department.

<u>Potential for re-disclosure</u>

For the safety and protection of your protected health information please be aware that under this authorization any information that is obtained by the above may be disclosed again by the person or organization to which it is sent. The privacy of the release information may not be protected under federal regulations.

Signature of Patient or legal Representative	Date

If signed by legal Representative, what is the relationship to patient:

INFORMED FINANCIAL INFORMATION

Please be advised that you will receive multiple bills for your procedure

ALL PATIENTS WILL RECEIVE THESE TWO BILLS:

1) **THERE WILL BE A BILL FROM THE FACILITY FOR USING THEIR BEDS, NURSES, SCOPES/INSTURMENTS, ETC.**
2) **THERE WILL BE A BILL FROM THE PHYSICIAN FOR PERFORMING THE PROCEDURE AND INTERPRETING THE RESULTS**

POTENTIAL BILLS:

1) **IF A BIOPSY IS TAKEN, IT WILL BE SENT TO A PATHOLOGIST FOR PROCESSING. YOU WILL RECEIVE A SEPARATE CHARGE FROM THE PATHOLOGY LAB.**
2) **IF ANESTHESIA IS ADMINISTERED, YOU WILL RECEIVE A SEPARATE CHARGE FROM THE ANESTHESIOLOGIST.**

TAKE NOTE:

- **IT IS THE PATIENT'S ULTIMATE RESPONSIBILITY TO FIND OUT FROM THEIR INSURANCE IF THE DOCTOR, THE FACILITY, OR THE LAB AND ANESTHESIOLOGY IS IN-NETWORK WITH THEIR PLAN**
- **PATIENT'S WILL BE RESPONSIBLE FOR ANY CO-PAY, CO-INSURANCE, OR DEDUCTIBLE AMOUNTS APPLIED BY THEIR INSURANCE PLANS.**
- **PLEASE CONTACT THE OFFICE 48 HOURS TO CANCEL OR RESCHEDULE YOUR APPOINTMENT TO AVOID A LATE CANCEL OR NO-SHOW FEE OF $300**
- **A SCREENING COLONOSCOPY COULD *POSSIBLY* CHANGE TO A DIAGNOSTIC COLONOSCOPY DURING THE COURSE OF THE PROCEDURE IF THE DOCTOR DETERMINES THERE IS A FINDING (I.E. LESION, POLYP).**

IF YOU HAVE ANY QUESTIONS, WE WILL BE HAPPY TO ANSWER THEM.

SIGNATURE______________________________ **DATE**____________________

CANCELLATION POLICY

OUR GOAL IS TO PROVIDE QUALITY HEALTH CARE TO ALL OUR PATIENTS IN A TIMELY MANNER. NO-SHOWS, LATE ARRIVALS, AND CANCELLATIONS INCOVENIENCE NOT ONLY OUR PROVIDERS, BUT OUR OTHER PATIENTS AS WELL. PLEASE BE AWARE OF OUR POLICY REGARDING MISSED APPOINTMENTS.

APPOINTMENT CANCELLATION

WHEN YOU BOOK YOUR APPOINTMENT, YOU ARE HOLDING A SPACE ON OUR CALENDAR THAT IS NO LONGER AVAILABLE TO OUR OTHER PATIENTS. TO BE RESPECTFUL OF YOUR FELLOW PATIENTS, PLEASE CALL OUR OFFICE AS SOON AS YOU KNOW YOU WILL NOT BE ABLE TO MAKE YOUR APPOINTMENT.
IF CANCELLATION IS NECESSARY, WE REQUIRE THAT YOU CALL AT LEAST 48 HOURS IN ADVANCE. APPOINTMENTS ARE IN HIGH DEMAND, AND YOUR ADVANCE NOTICE WILL ALLOW ANOTHER PATIENT ACCESS TO THAT APPOINTMENT TIME.

HOW TO CANCEL YOUR APPOINTMENT

IF YOU NEED TO CANCEL YOUR APPOINTMENT, **PLEASE CALL US AT THE OFFICE AT (530) 243-8667. PHONE HOURS ARE 8:30AM-12:00PM AND 1:30PM-4:00PM MONDAY THROUGH THURSDAY AND 8:30AM-12:00PM ON FRIDAYS.** IF NECESSARY, YOU MAY LEAVE A DETAILED VOICEMAIL MESSAGE. WE WILL RETURN YOUR CALL AS SOON AS POSSIBLE.
IF YOU ARE SCHEDULED FOR A PROCEDURE AT REDDING ENDOSCOPY CENTER YOU CAN CALL (530) 246-7000 AND CANCEL BETWEEN 7:00AM -4:00PM MONDAY THROUGH FRIDAY.

LATE CANCELLATIONS/NO-SHOWS

A CANCELLATION IS CONSIDERED LATE WHEN THE APPOINTMENT IS CANCELLED LESS THAN 48 HOURS BEFORE THE APPOINTMENT TIME. A NO-SHOW IS WHEN A PATIENT MISSES AN APPOINTMENT WITHOUT CANCELLING. **WE REQUIRE A 48 HOUR ADVANCE NOTICE OF CANCELLATION.**

FOR NEW PATIENTS' FIRST APPOINTMENTS, A NO-SHOW OR LATE CANCELLALTION WILL RESULT IN A FULL CHARGE OF THE NEW PATIENT FEE AND WILL REQUIRE A NEW REFERRAL FROM YOUR REFERRING PROVIDER.

SIGNATURE______________________________ **DATE**____________________

NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGE OF RECEIPT OF NOTICE

A COPY OF OUR HIPAA/PRIVACY PRACTICES IS POSTED IN THE LOBBY. IF YOU WOULD LIKE A COPY ONE WILL BE GIVEN TO YOU UPON REQUEST. I ACKNOWLEDGE THAT I HAVE ACCESS TO THE OFFICE PRIVACY PRACTICES.

SIGNATURE______________________________ **DATE**____________________

MEDICAL/INSURANCE INFORMATION

Please give the receptionist a copy of your Medicare and / or insurance card(s) so that a copy can be obtained. We are contracted with MOST insurance companies, but it is best if you check with the insurance carrier for this information. Medicare related cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as full charge, and patient is responsible only for the deductible, co-insurance, and non-covered services; co-insurance and deductible are based on the Medicare carrier. **All co-pays, co-insurance and deductibles are payable at the time of service.** These fees will be collected at check-in if they are known in advance, otherwise this will be collected at check-out. Any fees related to co-pay or deductibles that are not collected during your visit will be billed to you, with billing statements sent to the address you provided. By signing below, I acknowledge agreement to the above policies.

Print name____________________ Signature____________________ Date__________

REDDING ENDOSCOPY CENTER

Leo E. Eickhoff, MD
P.K. Dhanuka, MD
B Nicholas Namihas,MD
Hongguang Liu, MD Prathibha
Chandrasekaran, MD

THE FOLLOWING ARE FOR YOUR RECORDS.

- **EXPLANATION OF YOUR BILL**
- **ANESTHESIA SERVICES**
- **HIPPA**
- **PATIENT RIGHTS**
- **CONSENT FOR RELEASE OF INFORMATION**

PLEASE READ THROUGH THEM CAREFULLY.

UPON THE ARRIVAL OF YOUR PROCEDURE DATE, YOU WILL BE ASKED TO SIGN THESE FORMS ELECTRONICALLY.

SHOULD YOU NEED TO READ THROUGH THEM AT THE TIME OF YOUR APPOINTMENT, THEY WILL BE READILY AVAILABLE TO YOU.

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EXPLANATION OF YOUR BILL

You are scheduled for a procedure at Redding Endoscopy Center. The total cost may be comprised of four provider fees: the Redding Endoscopy Center's fee, the physician's fee, the anesthesia fee, and the pathologist's fee. Each individual provider bills fees separately.

- **Redding Endoscopy Center's fee** covers the cost of providing the technicians, nurses, equipment and supplies involved in the performance of your service. Co-pays, Co-insurance, and Deductibles are due at the time of service. If your insurance company finds you are responsible for an additional balance after processing the claim, you will be billed separately for that amount and payment will be due within 30 days. If you have any questions regarding your bill from Redding Endoscopy Center, please call their **Billing Department** at **(866) 809-1220**.

- The **Physician's Professional Service fee** is for providing the endoscopy procedure, supervising, interpreting and consulting with you and your referring physicians. Your physician will bill you separately for the physician's professional fee. If you have and questions regarding your physician's bill, please call their respective billing offices. **R.D.N.E.C. Billing Department** at **(530) 243-8667**. **Dr. Liu** at **(530) 338-2406**.

- The **Anesthesia fee** covers the cost of providing Propofol anesthesia for your procedure. If you have any questions regarding your bill from anesthesia, please call their **Billing Department** at **(866) 809-1220.**

- The **Pathology fee** is for services if there are biopsies taken during your procedure. You will be billed by Pathology groups reviewing the tissue. Please call them with billing issues. Unless instructed otherwise, your specimen will be sent to the below laboratories. If a different laboratory is preferred, please bring the laboratory information with you.

GI Pathology – **1-888-274-7956** **Shasta Pathology** – **(530) 255-1000**

Interpreting your insurance explanation of benefits (EOB):

- **Total Charges**: This is the total amount each provider will bill to insurance.
- **Allowed Amount**: This is the total amount expected to be paid by insurance and/or patient combined. (It is also called the negotiated amount or contracted amount).
- **Payable Amount**: This is the amount that the primary insurance will pay.
- **Patient Responsibility**: This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the "patient responsibility", depending on your contract.

I have read and understand the above information.

FINANCIAL AGREEMENT

All Co-Insurance and deductible balances for Redding Endoscopy Center (REC) will be collected at the time of service. If there are any additional amounts due, you will receive a bill from Redding Endoscopy Center. You will also be receiving a bill from the Physician for professional fees and if you have a biopsy during your procedure you will receive a bill from the pathology laboratory. Anesthesia services will be billed separately. In the event that your insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physician which render services 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 regulation of a State or federal agency to process such a claim. We will expect payment of co-pays and co-insurance at the time of service. Redding Endoscopy Center is a Medicare provider and accepts Medicare assignment. If you have a second insurance, REC will bill them as a courtesy. All co-insurance balances and deductibles are your responsibility and due at time of service. We will bill your first and any subsequent insurance as a courtesy. It is, however, your contract with the insurance company and the final payment is always your responsibility. If your insurance requires a PRIOR AUTHORIZATION for procedure it is YOUR responsibility to contact the performing physician's office to obtain an authorization prior to your appointment. If you do not have an authorization at the time of appointment and we are unable to obtain one, your appointment will be rescheduled. If we provide services without prior authorization, at your request, YOU ARE RESPONSIBLE FOR THE ENTIRE FEE (100%). PAYMENT IS DUE AT THE TIME OF SERVICE. Redding Endoscopy Center will not bill your insurance in this situation. The Center is not a Medi-Cal provider; however your current Medi-Cal Plan information is required at the time. The Center is a Partnership Health Plan provider; please provide your current Partnership HP information. All share costs are your responsibility and due at time of service. Payment for services rendered is due at the time of service. Payment in full is required for all self-pay patients at the time of service for all visits. If you need to make financial arrangements, please make them prior to your visit.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Redding Endoscopy Center, my admitting physician, or other physicians who render services 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 Redding Endoscopy Center, my admitting physicians or other physicians who render services to charge not paid for within a reasonable period of time by insurance or third party payer. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all court costs and reasonable attorney fees. I hereby authorize Redding Endoscopy Center to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize Redding Endoscopy Center, my admitting physician, or other physicians who render services to release all or part of my medical records where required 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. This is referred to in the notice of privacy practices and in the patient rights.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my procedure that the physicians who perform procedures/services at Redding Endoscopy Center may have ownership interest in Redding Endoscopy Center. The physician has given me the option to be treated at another facility, which I have declined. I wish to have my procedure(s) performed at Redding Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

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

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to the date of the procedure. I have also received information regarding Redding Endoscopy Center policies pertaining to ADVANCE DIRECTIVES prior to the date of the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

I have a properly executed Advance Directive that is approved by the State of California: **YES_____** **NO______**

If yes, I am providing the center a copy of such today and ask the center to follow my wishes as outlined on this document should I no longer be able to make decisions for myself: **YES______** **NO______**

I would like information on Advance Directives. YES____ N/A____ Declines____

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

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ANESTHESIA SERVICES

Redding Endoscopy Center is now offering state of the art advanced anesthesia services to its patients.

Propofol is an IV drug administered by a Certified Registered Nurse Anesthetist (CRNA), who is highly trained and specialized to safely administer your sedation. Propofol has distinctive advantages over other medications in that it generally produces a much deeper level of sedation, ensuring that you will be asleep and comfortable during the procedure, yet allow you to wake up and recover much faster after the procedure is completed.

The CRNA will carefully deliver medications while monitoring your vitals signs (pulse, blood pressure, respiratory rate, EKG rhythm strip, and pulse oximetry) during your procedure. Based upon your medical history and condition, your physician, nurse practitioner, or physician assistant will recommend that you have either Propofol administered by a CRNA or alternative forms of IV conscious sedation.

Please note that charges for anesthesia services (CRNA) are separate from and in addition to 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. In the event your insurance will not cover anesthesia (CRNA) administered Propofol IV sedation for your endoscopic procedure, alternative self-payment arrangements for these important services can be made with the billing department at 1-866-809-1220.

___________ (Initial Here) I agree to receive anesthesia services, as recommended by my physician/nurse/practitioner/physician assistant/CRNA administered IV Propofol, and I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance. I understand anesthesia is billed by time and the billed charges for anesthesia services can range between $1400-$2000

Non Coverage of anesthesia for services provided

___________ (Initial Here) I am aware that my insurance company may not cover this service and I acknowledge that I will be billed the following fees if my insurance company denies payment. **$200 flat fee** for anesthesia services will be billed to the patient.

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby authorized Redding Endoscopy Center to use and/or disclose my health information which specifically identified me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Redding Endoscopy Center can refuse to treat me.

I have been informed that Redding Endoscopy Center has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Redding Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Redding Endoscopy Center took before receiving my revocation.

I understand that Redding Endoscopy Center has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Redding Endoscopy Center restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Redding Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to, Redding Endoscopy Center must adhere to such restrictions.

NOTICE OF PRIVACY PRACTICES

Redding Endoscopy Center - 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

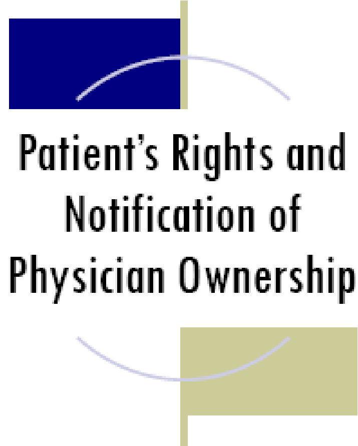
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized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

Contact Person

If you have any questions, requests, or complaints, please contact: Center Director(530) 246-7000

REDDING ENDOSCOPY CENTER

2179 Court St.
Redding, CA 96001
(530) 246-7000



Leo E. Eickhoff, MD
P.K. Dhanuka, MD
B Nicholas Namihas,
MD Hongguang Liu, MD
P. Chandrasekaran, MD

PATIENT'S BILL OF RIGHTS:

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.

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

To appropriate assessment and management of pain.

Be advised as to the absence of malpractice coverage.

Be advised if the physician has a financial interest in the surgery center.

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 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.

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 care are 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 LABEL

Redding Endoscopy Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Redding Endoscopy Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Redding Endoscopy Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Redding Endoscopy Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

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.

Redding Endoscopy Center 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 an Advance Directive which has 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:
Jamie Whitmoor-Pryer, Center Director
2179 Court Street, Redding, CA 96001
Phone: 530.246.7000

You may contact the state to report a complaint:

Office of the Inspector General: **http://oig.hhs.gov**

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

Local Department of Health Services:
California Dept. of Public Health Licensing & Certification Program
126 Mission Ranch Blvd.
Chico, CA 95926
Complaints 1-800-554-0350 Fax 530-895-6723

MEDICARE:
Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.

Medicare Ombudsman Web site: **https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home**

Medicare: www.medicare.gov or call 1-800-MEDICARE
1-800-633-4227

AAAHC:
This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
3 Parkway North Blvd, Suite 201
Deerfield, IL 6001 5
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:

B Nicholas Namihas, MD
Hongguang Liu, MD
P. Chandrasekaran, MD
Leo E. Eickhoff, MD
P.K. Dhanuka, MD

By signing below I acknowledge having been given a copy of the Patient's Rights & Physician Notification of Ownership.

PATIENT LABEL