IMPORTANT PAPERS!

PLEASE COMPLETE ALL FORMS

FRONT & BACK

PLEASE DATE FORMS ON THE DAY YOU RECEIVE THEM.

WHEN YOU ARRIVE AT THE FACILITY, REGISTRATION STAFF WILL WITNESS ALL THE FORMS YOU HAVE ALREADY SIGNED.

THANK YOU!

RIVERSIDE ENDOSCOPY CENTER
2151 RIVERSIDE AVENUE
JACKSONVILLE, FLORIDA 32204
(904) 388-8686 PHONE (904) 388-4445 FAX

Thank you for choosing Riverside Endoscopy Center for your gastroenterology services. Riverside Endoscopy Center has been granted a Certificate of Accreditation by The Joint Commission (TJC). This certification recognizes our commitment to high quality care and substantial compliance with the standards for ambulatory health care organizations.

PLEASE READ THE FOLLOWING INFORMATION PRIOR TO YOUR PROCEDURE SO THAT YOU COMPLETELY UNDERSTAND THE FINANCIAL ASPECT OF THE PROCEDURE.

1. Payment is expected at the time of service unless other arrangements have been made in advance. Actual reimbursement for charges will vary depending on your type of insurance coverage. Any co-payment, co-insurance or deductible amounts will be collected at the time of your procedure. This is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud.
2. We accept payment by cash, check, money order, Visa, and MasterCard . You will receive a statement for any remaining balance which is due upon receipt. Our office will charge a $25 fee for all returned checks.
3. Please contact our office for special payment arrangements.
4. We will submit insurance claims on your behalf. Information needed to process your claim with your insurance company should be received and verified prior to your appointment.

5. Coverage for your procedure is determined by your contract with your insurance company. We recommend that you contact your insurance company before receiving services.

6. Your insurance may provide different coverage for a "screening" procedure versus a "diagnostic" procedure.
   - A procedure is usually considered "screening" if you have no symptoms, biopsy or lesion removal.
   - A procedure is considered "diagnostic" if you are having a problem or symptoms.

7. You may incur charges for the following services related to your procedure:

   Physician Fee ⇨ The fee for the physician performing your procedure.
   Facility Fee ⇨ The fee for the use of the facility for your procedure.
   Pathology Fee ⇨ If a biopsy is required, you may incur a fee from the Labatory.
   Anesthesia Fee ⇨ The fee for administration of anesthesia. You may incur a fee from American Anesthesiology of North Florida.

Our staff will do their very best to help you with questions and guide you to the proper sources of information. If you have any questions, please contact us at (904) 388-5265

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text
of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which
served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations,
medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
A patient is responsible for following the treatment plan recommended by the health care provider.
A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Name_____ Date_____

Date of Birth_____

Patient's Bill of Rights and Responsibilities & Privacy Practices

I have read and received a copy of my "Patient's Bill of Rights and Responsibilities and notice of Privacy Practices."

State of Florida Reporting Requirement:

The State of Florida requires that Health Care Providers collect and report patient demographic information quarterly, one of the reportable items is Racial Classification.

Please circle the appropriate classification from the following list provided below:

Asian/Pacific Islander	African American	Caucasian
Native American	Hispanic	No Response

I have reviewed and agree to the above:

_____

Patient Name

_____

Signature of Patient or Responsible Party Date

_____

Witness Date

AMBULATORY SURGERY CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWERS OF ATTORNEY

All patients have the right to participate in their own healthcare decisions and to make advance directives or execute Powers of Attorney that authorize others to make decisions on their behalf based on the patients expressed wishes when the patient is unable to make decisions orunable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform high risk procedures. Most proceduresperformed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of yourprocedure with your physician who can answer your questions as to its risk, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advanced directive or instruction from a Health Care Surrogate or Attorney InFact, that if an adverse event occurs during your treatment at this Facility we will initiate resuscitative or other stabilizing measures andtransfer you to an Acute Care Hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive or Healthcare Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

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?

☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.

☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.

☐ I would like to have information on Advance Directives.

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 LAST NAME	PATIENT'S FIRST NAME	DATE

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent orauthorization.

I ACKNOWLEDGE THAT I HAVE READ 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 _____

Disclosure of Ownership

Your physician may have a limited partnership interest in the center. A complete list of physician limited partners is available at the center and, if applicable, your physician's ownership will be highlighted when you register. If you have any questions about physician ownership contact the center at 904-388-8686.

Medical Malpractice Coverage

Your physician may not carry traditional malpractice insurance coverage. If you have questions about malpractice coverage, please discuss those with your physician.

Patient Complaint or Grievance

- If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern (s) promptly.
- If necessary, your problem or complaint will be advanced to the Administrator and/or Nurse Manager for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.
- If you are not satisfied with the response of the Surgery Center, you may contact one of the following agencies:

Complaints against the **ambulatory surgical center** may be filed with the state of Florida Consumer Services Unit at 1-888-419-3456 (Press 2), or write to the address below:

Agency for Health Care Administration
Consumer Assistance Unit
2757 Mahan Drive/BLDG. 1
Tallahassee, Florida 32308

Complaints against a **health care professional** and want to receive a complaint from, call Consumer Services Unit at 1-888-419-3456 (Press 2), or write to the address below:

Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage at:

www.cms.hhs.gov/center/ombudsman

By signing this document, I acknowledge that I have read and understand its contents:

_____

Patient Name Date Received

_____

Date of Birth

LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?
Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?
A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death, and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?
Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?
Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?
Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?
Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?
The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?
Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?
If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.

Patient Name_____ Date of Birth_____

Date_____

General Medical Information:

Patient Name_____ Date of Birth_____

Current Primary Care Physician_____

Do you drink alcohol regularly? Yes/No How many drinks per week?_____

Do you smoke? Yes/No How much?_____

Past Medical History:

Surgical History: _____

_____

Have you ever experienced any of the following: Circle all that apply

Hypertension Heart Attack Hepatitis Heart Valve Replacement Seizures Diabetes
Kidney Disease Cancer (Type) _____

Other_____

Recent Symptoms:

Circle symptoms you are currently having or have had recently:

Constipation Dark Urine Rectal Itching Diarrhea Indigestion Yellowish Skin

Rectal Bleeding Black Stool Abdominal Pain Vomiting Blood

Nausea/Vomiting-how long_____ Weight Loss-how many pounds_____

Difficulty swallowing liquids Difficulty swallowing Solids

Other_____

Personal History:

Last Colonoscopy & Where_____

Last Flexible Sigmoidoscopy & Where_____

Last Upper Endoscopy & Where_____

Family History: State who (parents, grandparents, siblings etc)

Colon Cancer (age)_____

Other Cancer-What kind_____

Riverside Endoscopy Center

Abdi Abbassi, MD Samir Habashi, MD Ajmal Hameed, MD

Name_____ SSI#_____

Street Address_____ City_____

State_____ Zip_____ DOB_____ Marital Status_____

Patient's Employer_____City_____State_____Zip_____

Ethnicity_____ Race _____ Language_____ Gender: Male/Female

Home Phone_____ Work Phone_____ Cell phone_____

Email_____

Emergency Contact_____Phone_____Relationship_____

Medication Allergies: _____

_____

Medication List: _____

_____

_____

_____