The forms listed below are enclosed in this packet and are required for your visit to the Center.

Please complete the forms on Pages 12 thru 23 and bring them with you on the day of your appointment.

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Welcome Notice

Welcome to the Greater New York Endoscopy Surgical Center. The Endoscopy Center is a private, freestanding, ambulatory surgery center located in Brooklyn, New York. The Center provides an appropriate setting in which members of its medical staff may perform outpatient ambulatory endoscopic procedures on their patients, consistent with the clinical privileges granted to each medical staff member by the Operator. The Center will establish and maintain the highest professional standards and commitment to excellence in care and considerate of the specific needs of our culturally diverse patient population.

In order to promote the highest quality of ambulatory endoscopic services, the Center will maintain a physical environment conducive to the provision of safe, efficient procedures; ensure that safe, effective and state of the art equipment and supplies are available for use by the Center's physicians and clinical staff; recruit, hire, affiliate with and maintain relationships with qualified, skilled physicians, other clinical staff, administrative staff, support staff and other providers; and provide effective continuing education and quality assurance/risk management programs. In addition, we serve as a resource for patients, families and physicians in the education and treatment of gastrointestinal diseases.

It is the mission of the Center to serve all persons in need of ambulatory endoscopic services, regardless of age, color, race, creed, national origin, religion, sex, sexual orientation, marital status, disability, payer source, or any other personal characteristics or qualification including the ability to pay.
DIRECTIONS TO ENDOSCOPY CENTER

From Manhattan:

Take Brooklyn Bridge from Manhattan, Merge onto I-278 W- Brooklyn Queens EXPY toward Verrazano Bridge, DO NOT TAKE VERRAZANO BRIDGE - Keep left to take Belt Pkwy E. On Belt Parkway for 3 – 4 miles until Coney Island Ave exit. Stay straight on service road and go to Ocean Avenue, make right on Ocean Avenue and then left on Emmons avenue. Go one block to 2211 Emmons Ave.

From Long Island:

North Shore:
Take Northern Pkwy W, Take Cross Island Pkwy to Belt Parkway W (OR) Take LIE towards New York, Take Cross Island Pkwy to Belt Parkway W …

South Shore:
Take Southern State Pkwy straight to Belt Pkwy W. …

Go 5 miles on Belt Parkway. Take Knapp Street exit; Stay straight on Service Road. Make left onto Ocean Ave, Left on Emmons Ave, go one block to 2211 Emmons Ave.

From New Jersey:

Take Goethals Bridge to Staten Island. Merge onto I-278 W- toward Verrazano Bridge, Keep left to take Belt Pkwy E. Take Coney Island Ave Exit. But stay straight on Service Road and go to Ocean Avenue, make right on Ocean Avenue and then left on Emmons avenue. Go one block to 2211 Emmons Ave.

From Queens:

EITHER 1. Take Cross Island Parkway South…OR 2. Take Van Wyke South to Belt Parkway West, Go 5 miles on Belt Parkway. Take Knapp Street exit; Stay straight on Service Road. Make left onto Ocean Ave, Left on Emmons Ave, go one block to 2211 Emmons Ave.

Revised 08/27/2013
Approved by: ST
PATIENT ESCORT POLICY

YOU MUST HAVE SOMEONE PICK YOU UP AFTER THE PROCEDURE

As a matter of patient safety, Greater New York Endoscopy Surgical Center enforces the New York State Ambulatory Surgical Center requirement that all patients having a procedure in our facility have an escort, that is, a companion, family member or friend, to accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888 943-8435) to arrange for a care partner to accompany you home from your procedure.

For additional information and to make arrangements for a care partner, you can visit the following website:

www.partnersincareny.org.

Or e-mail:

par_intake@vnsny.org.

Please note that your procedure cannot be performed unless your escort is verified.

Thank you for your cooperation.
PERSONAL POSSESSIONS NOTICE

Greater New York Endoscopy Surgical Center will provide you with a handbag to store your personal belongings during the procedure.

Please **DO NOT** wear jewelry, **DO NOT** bring laptops, **DO NOT** bring iPods or any other valuables when you come to the Center.

Please note that Greater New York Endoscopy Surgical Center assumes no responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.
An upper endoscopy or EGD (EsophagoGastroDuodenoscopy) involves the insertion of a lighted flexible tube, called an upper endoscope, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

***

A colonoscopy involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of an electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

***

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure there are risks that may occur with any surgical or medical procedure. There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

Further information about these procedures can be obtained at the following organization websites: www.gnyesc.com

Brooklyn Gastroenterology & Endoscopy
www.nygicare.com

The American College of Gastroenterology:
www.acg.qi.org/patients/

The American Society for Gastrointestinal Endoscopy:
www.askasge.org/
Frequently Asked Questions (FAQ’s)

The following list of questions and answers may assist you in preparing for your procedure:

Q)  I am having an upper endoscopy.  Do I have to do anything to prepare for this procedure?
A)  There is no specific preparation but you should not eat or drink anything after 8:00 PM the night before the test (unless directed otherwise)

Q) My procedure is scheduled for the afternoon. Can I eat or drink anything the morning of the procedure?
A)  You should not eat anything after midnight.  You may have up to 1 cup of clear liquid four hours prior to your scheduled arrival time at Greater New York Endoscopy Surgical Center.

Q)  Will my procedure be painful?
A)  No.  The Center is fully staffed with Board-certified anesthesiologists to ensure that your procedure is comfortable.

Q)  How long will I be at the Center?
A)  You will be at the Center approximately 2 hours in total.  You will spend less time at the center by making certain you are punctual for your appointment.  Arriving earlier than your appointment time won’t necessarily get you through faster, while arriving late will probably cause you to lose your scheduled time slot and create substantial delays for you.  
Completing the required paperwork (available online or by mail) prior to your arrival, will expedite the process.

Q) Do I have to bring an escort with me?
A)  Yes.  The Center requires that you have an escort to take you home.

Q)  My doctor has all my insurance information.  Do I need to bring my insurance card and billing information?
A)  Yes.  Greater New York Endoscopy Surgical Center is an independent entity and has no connection to your doctor’s office.

Q)  Will I receive a bill?
A)  Yes.  We will bill your insurance company or HMO directly first.  As required by law, you will be billed for your co-payment, deductible and co-insurance.  **Please note that some insurance companies may send payment directly to you for the facility and anesthesia service.  We expect that you will forward this payment directly to Greater New York Endoscopy Surgical Center.
FAQ’s (continued): Special Medical Considerations

Q) Do I take my heart medications on the day of my procedure?
A) In general, you **should** continue to take prescribed medications before and after gastrointestinal endoscopy without modification. Essential medications may be taken on the day of your procedure with a small amount of clear liquid. There are some types of cardiovascular medications, however, that should not be taken on the day of your procedure; these include diuretics, ACE inhibitors, and angiotensin II receptor blockers. If you are unsure if the medications you take fall into these categories, please ask your physician or consult the following website: [www.webmd.com/drugs](http://www.webmd.com/drugs).

Q) I am a diabetic. Should I take my medication on the day of my procedure?
A) In general, diabetic medication should **not** be taken on the day of your procedure. **There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary physician.** A finger stick blood sugar will be obtained by the Greater New York Endoscopy Surgical Center staff to ensure proper management of your blood sugar during your procedure. When the procedure is over and you have resumed a normal diet, your usual diabetic regimen should be resumed.

Q) I have been told to take prophylactic antibiotics prior to dental work. Do I need to take antibiotics before my endoscopic procedure?
A) With rare exceptions, the procedures performed at Greater New York Endoscopy Surgical Center do **not** require the administration of prophylactic antibiotics. If, however, you are advised by your physician to take antibiotics prior to gastrointestinal endoscopy, you may take them orally, 1 hour prior to the procedure, with a small amount of clear fluid. If you are uncertain if you require anti-biotics prior to your GI Endoscopy procedure or if you need a prescription, please call your doctor prior to your appointment.
Q) I take aspirin, or anticoagulants or other blood thinners. Do I need to stop these medications before my procedure?

   A) **DO NOT STOP ANY ANTICOAGULANT WITHOUT A CLEAR DISCUSSION WITH YOUR DOCTOR!** In general, anticoagulants and other blood thinners should be stopped prior to your Colonoscopy or Endoscopic Ultrasound. This is to reduce the chance of bleeding if biopsies are obtained or polyps are removed. In general anticoagulants do not need to be stopped for Upper Endoscopy. In General, for All Procedures Performed at The Center, Aspirin does not need to be stopped. *If you have any questions about stopping these medications, consult your primary physician.*

Q) What if I am pregnant or may be pregnant – should I undergo gastrointestinal endoscopy?

   A) If you are pregnant, you should consult with your physician about whether you should undergo gastrointestinal endoscopy. If you are a woman of child-bearing age, Greater New York Endoscopy Surgical Center under certain circumstances will administer a pregnancy test prior to your procedure in order to optimize your management.

Q) I am breast feeding my baby. Is the procedure safe for my baby?

   A) In general, women who are breast feeding may safely undergo gastrointestinal endoscopy – the administered anesthetic is not excreted in significant quantities in breast milk. Some mothers elect to store milk via a breast pump and feed the child with the pumped milk on the day of the procedure. Normal breast feeding may resume the following day.

Q) What should I do if I have an Emergency, severe pain, bleeding, fever?

   A) Call your doctor and/or the Center (718-954-3535) After hours the number is forwarded to the medical director. Or call the Medical Director at 516-316-0830.

Q) What should I do if I want to change providers?

   A) You have the right to change your physician at any time. The Center will provide you with a physician affiliated with the Center and arrange a careful transfer of care.
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.

I. What this is:
This Notice describes the privacy practices of Greater New York Endoscopy Surgical Center

II. Our Privacy Obligations
We are required by law to maintain the privacy of medical and health information about you (“Protected Health Information” or “PHI”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization
In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our “health care operations” (e.g., internal administration, quality improvement and customer service) as detailed below:
  - Treatment. We use and disclose PHI to provide treatment and other services to you—for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
  - Payment. We may use and disclose PHI to obtain payment for services that we provide to you—for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”), or to verify that your Payor will pay for health care.
  - Health Care Operations. We may use and disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our administrators in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Nurse Administrator.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person’s involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

M. Workers’ Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs.

N. As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Use and Disclosures Requiring Your Written Authorization
A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form (“Your Authorization”). For instance, you will need to execute an authorization
V. Your Individual Rights

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our Nurse Administrator. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Nurse Administrator will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Nurse Administrator and submit the completed form to the Nurse Administrator. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Nurse Administrator and submit the completed form to the Nurse Administrator. If you request copies, we will charge you $0.75 for each page copied.

You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor’s medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).

E. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Special Authorization, or Your Marketing Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Nurse Administrator identified below. [A form of Written Revocation is available upon request from the Administrator.]

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Nurse Administrator and submit the completed form to the Nurse Administrator. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you $10.00 per page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Center and on our Internet site at www.gnyesc.com. You may also obtain any revised notice by contacting the Administrator.

VII. Medical Director:

You may contact the Medical director at: Scott Tenner, MD MPH
2211 Emmons Ave
Brooklyn, NY11235
C: (516) 316-0830
F: (718) 954-3548
Scott.tenner@downstate.edu
Patient Rights & Responsibilities

The patient has the right to:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor.
2. Be treated with consideration, respect and dignity including privacy in treatment.
3. Be informed of the services available and applicable charges at the Center.
4. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
5. Be informed of the provisions for after hours and emergency care.
6. Receive an itemized copy of his/her account statement, upon request.
7. Obtain from his/her Physician, or the Physician’s delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand and to participate in decisions involving the planned treatment. When it is medically inadvisable to give such information to a Patient, the information is given to a person designated by the patient or legally authorized representative.
8. Receive from his/her Physician information necessary to give informed consent prior to the start of any procedure or treatment or both. An individual consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision.
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
10. Refuse to participate in experimental research.
11. Voice grievances and recommend changes in policies and services to the Center’s staff, the operator and the New York State Department of Health without fear of reprisal.
12. Express complaints about the care and services provided and to have the Center investigate such complaints. If the patient is not satisfied by the Center’s response, the patient may complain to the New York State Department of Health’s Metropolitan Area Regional Office (MARO) at 212-417-5940 and/or NYSDOH Complaints (800)-804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient’s treatment.
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any Health Care Practitioner and/or Health Care Facility except as required by law or third-party payment contract.
15. Access their medical record pursuant to the provisions of the law.
16. Expect the Physicians and staff to be fully qualified to provide the necessary care and treatment.
17. Change primary or specialty Physicians, if other qualified Physicians are available.
18. Be informed regarding the absence of Physician malpractice insurance coverage.
20. To receive pain management services.

The patient has the following responsibilities:

1. To provide the Center with accurate and complete medical information.
2. To ask all questions you may have regarding the treatment provided by the Center.
3. To consent by free will to all procedures or treatments.
4. To inform the Center if procedures or treatments are not understood.
5. To follow after-care instructions as recommended by the Physician.
6. To contact his/her Physician with post-testing questions or concerns.
7. To provide all necessary information regarding third-party payment sources.
8. To observe all the Center’s Policies, Procedures and Regulations.
9. To keep appointments as scheduled, or advise the Center in a timely manner if an appointment cannot be kept.
10. To be considerate of other Patients and Personnel and respect the property of others and the Center.

___________________________________________________________  __________________________
Patient Signature Date

___________________________________________________________
Printed Name of Patient
PATIENT REGISTRATION

Today’s Date __________________ Date of Birth __________________ Age _______ Social Security# __________________

Patient Name ____________________________________________________________________ Gender M F Marital Status S M W D
(First Name) (MI) (Last Name)

Address ____________________________________________________________________________
(Street) (Apt#) (City) (State) (Zip Code) (County)

Home Phone _______________ Cell Phone _______________ Alternate Phone _______________ E-mail Address _______________

Ethnicity – Do you consider yourself Hispanic/Latino? Y ____ N _____ Declined ___ Unavailable/Unknown _____ Primary Language ________

Race – Which category best describes your race? ____ American Indian/Alaskan Native ____ Asian ____ Black or African American ____ White
____ Native Hawaiian/Pacific Islander ____ Multiracial ____ Declined ____ Unavailable/Unknown

Emergency Contact _________________________________ Telephone _______________________ Relationship _________________________

Person that will escort you upon discharge from the Center: Name __________________ Telephone # __________________

Employer __________________________________________________ Occupation __________________ Work Phone __________________

Address __________________________________________________________________________
(Street) (City) (State) (Zip Code)

************************************************************************************************************************
Send Report to Dr.: __________________________________ Address __________________________________________________________

Referring Physician Telephone _____________________________ Referring Physician Fax ____________________________

************************************************************************************************************************
Do you have any allergies? ☐ Yes ☐ No Allergies to Latex? ☐ Yes ☐ No Allergies to food? [Please list] ________________________________
Allergies to medications? ☐ Yes ☐ No [Please list drug names] ________________________________________________________________

************************************************************************************************************************
Primary Insurance Company Name _________________________________________ Hosp Medical Ins Phone # __________________
Address ______________________________________________________________ Group # _______ ID # __________
Name of Insured ______________________ Date of Birth ______________ SS # __________________ Relationship _________________________

Secondary Ins. Company Name ____________________________________________ Hosp Medical Ins Phone # __________________
Address ______________________________________________________________ Group # _______ ID # __________
Name of Insured ______________________ Relationship ______________ DOB ______________ SSN# ______________

I, the undersigned, have insurance with __________________________ and assign benefits directly to the provider for all medical benefits, if any,
only payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.
I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my
insurance submissions.

Patient’s signature: __________________________________________________________________________

Do You Have A Health Care Proxy ☐ No ☐ Yes If Yes, Type: ______________ Copy Provided? ☐ N/A ☐ No ☐ Yes

************************************************************************************************************************
By signing below, I acknowledge receiving a copy of the Center’s Notice of Privacy Practices and the Patients Bill of Rights and Responsibilities.

Patient’s Signature: __________________________________________________________________________

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter’s Signature: __________________________________________________________________________
**MEDICATION LIST AND RECONCILIATION**

Please list all medications you are currently taking and include the dose.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose (i.e. mgs.)</th>
<th>Frequency</th>
<th>Date of Last Dose</th>
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**FOR DOCTOR’S USE ONLY-(Please check)**
CONTINUE WITH PREVIOUS MEDICATION [YES] [NO]

Changes to Medications

<table>
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<tr>
<th>Name</th>
<th>Dose (i.e. mgs.)</th>
<th>Number of times per day</th>
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# PRE-ENDOSCOPY QUESTIONNAIRE

**NAME:** ________________________________  **REFERRING MD:** ________________________________

1. **Do you have any other medical conditions we should be aware of?**
   - [ ] Yes  [ ] No
   
   If yes, please explain ________________________________________________________________

2. **Do you take any medication regularly?**
   - [ ] Yes  [ ] No

3. **Do you have any allergies to medications or drugs?**
   - [ ] Yes  [ ] No
   
   If yes, please list. ________________________________________________________________

4. **Do you have any food allergies? i.e. eggs or soy?**
   - [ ] Yes  [ ] No

5. **Do you take the aspirin products on a regular basis?**
   - [ ] Yes  [ ] No
   
   **If yes, these products must be discontinued. Please consult your physician.**

6. **Do you take non-steroidal anti-inflammatory on a regular?**
   - [ ] Yes  [ ] No
   
   *(i.e. Advil, Motrin, Aleve, Naprosyn, Moibic, Clinoril, Celebrex)*
   
   **If yes, these products must be discontinued. Please consult your physician.**

7. **Do you take Coumadin or any other anti-coagulant medications?**
   - [ ] Yes  [ ] No
   
   **If yes, these products must be discontinued. Please consult your physician.**

8. **Do you have diabetes?**
   - [ ] Yes  [ ] No

9. **Do you take insulin?**
   - [ ] Yes  [ ] No

10. **Have you ever been told that you have a heart condition?**
    - [ ] Yes  [ ] No
    
    If yes, please explain ________________________________________________________________

11. **Have you ever been told to take antibiotics before a procedure?**
    - [ ] Yes  [ ] No
    
    If yes have you taken your antibiotics prior to procedure?  
    - [ ] Yes  [ ] No

12. **Have you ever had a bleeding problem?**
    - [ ] Yes  [ ] No

13. **Have you ever had surgery?**
    - [ ] Yes  [ ] No
    
    If yes, please explain. ________________________________________________________________

14. **Have you ever had any problems with anesthesia?**
    - [ ] Yes  [ ] No
    
    If yes, please explain. ________________________________________________________________

15. **Have you ever had an endoscopic procedure? (colonoscopy or gastroscopy)**
    - [ ] Yes  [ ] No
    
    **If yes, please provide the details ________________________________________________________________**

16. **Is there any other information we should know about?**
    - [ ] Yes  [ ] No

    ________________________________________________________________

**Completed By ________________________________ Date: __________________________**

**CENTER PERSONNEL**

[ ] No Pre-Procedure Required ________________________________

[ ] Pre –Procedure Testing Needed (specify) ________________________________

Reviewed By: ________________________________ Date: __________________________

______________________________  __________________________
Signature/Title
OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work.

Statutory authority; Public health law, §238 a (10)

The Following Persons/Physicians Are The Owners Of The Center:

Scott Tenner, MD
Robin Baradarian, MD
Grigory Pogrebinsky, MD
Charles N. Friedlander, MD
John Ackert, MD
James Salik, MD
Alex Sherman, MD
Hillel Tobias, MD
Scott Weber, MD
Richard Ventimiglia
Giovanna Guerci

I, ____________________, confirm that I have read and fully understand the above statements that have been presented/told to me in this document.

_______________________________________
Signature
Acknowledgement of Greater New York Endoscopy Surgical Center Distribution and Patient Review

Notice of Privacy Practices
Ownership Disclosure
Patient Rights
Advanced Directives Policy

For the patient’s personal protection, the state of New York requires each patient to acknowledge in writing that they have received a copy of the Center’s Notice of Privacy Practices.

I acknowledge that the Center may use and disclose my health information for the purposes of treating, obtaining payment for services rendered and performing routine healthcare operations and services in the Center.

By signing below, I hereby acknowledge receipt and review of more than 24 hours prior to my procedure of the:

Notice of Privacy Practices
Ownership Disclosure
Patient Rights
Advanced Directives Policy

Print Name: ________________________________

Signature: ________________________________ Date: ____________________________
GREATER NEW YORK ENDOCOPY SURGICAL CENTER

Financial Policy

Greater New York Endoscopy Surgical Center, GNYESC, is a for-profit endoscopy facility dedicated to providing gastroenterologists and patients a safe and effective environment for the performance of procedures related to the gastrointestinal tract. The facility will bill an appropriate “facility fee” for the performance of endoscopic procedures: Physicians who use the facility, including endoscopists and anesthesiology will bill a separate “professional fee” to be paid directly to themselves. This fee has no relationship to the facility payment other than they are generated at the same procedure. Billing, payment, collection and participation with carriers may differ considerably between the facility and physician involved in the procedures at the facility.

A professional attitude shall be used whenever communicating with patients and insurance companies regarding payment for services rendered. Appropriate staff will assure that the patient understands the implications of his insurance coverage, if any and the resulting personal financial obligation and responsibility for payment for services rendered.

As you know, the world of health insurance has become increasingly confusing and complex for patients and physicians alike. For this reason, we would like to bring to your attention that we are legally required to bill you for any applicable co-payments or co-insurance and/or deductibles which your insurance plan requires you to personally pay under the terms of your insurance policy according to the State of New York Insurance Department opinion (see www.ins.state.ny.us/ogco2003/rg030409.htm). The Federal and State governmental agencies that oversee the health insurance industry have consistently taken the position that the routine waiver of co-payments and co-insurance by healthcare providers may constitute insurance fraud by the insured and the physician. Within 6 months of receiving a response from your carrier, you will receive a “balance bill”. These amounts reflect that portion of our facility fees which were not paid by your insurance company and that remain as your personal responsibility.

According to the State of New York Insurance Department opinion referenced above, a decision in the exercise of business judgment by a physician not to pursue the full legal remedies available to collect a debt would not constitute insurance fraud. If payment of your full outstanding balance is not financially feasible for you at this time, please call our office and we will try to work out a mutually-agreeable payment plan that you can afford to pay over a reasonable period of time.

For patients who have a sizable financial obligation after payment by insurance, or for patients who have no insurance coverage, a payment contract or the use of a credit card may offer the opportunity to satisfy the financial obligation. For those patients wishing to satisfy their balance due via a financial agreement, the patient or responsible party will be required to sign a contract prior to the procedure. Patient or responsible party will be given a copy of the signed agreement, and the original will be maintained by the Accounts Receivable Office.

By signing below, I acknowledge receiving a copy of the Center’s Financial Policy

Patient’s Signature: ___________________________ Print Name: ___________________________
Witness Signature: ___________________________ Print Name: ___________________________

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter’s Signature: ___________________________ Print Name: ___________________________
UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: ________________________________  Med. Rec. #: ________________________________

Physician: ________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above named medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Greater New York Endoscopy Surgical Center to release medical information in the event of any emergency transfer to an Acute Care Facility.

______________________________  ________________________________
Signature of Patient or Authorized Representative  Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named medical facility sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. In addition, I am giving the laboratory permission to bill my insurance company.

______________________________  ________________________________
Signature of Patient or Authorized Representative  Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

______________________________  ________________________________
Signature of Patient or Authorized Representative  Date
NOTE: If Medicare doesn’t pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect Medicare may not pay for the items listed or checked in the box below.

<table>
<thead>
<tr>
<th>Listed or Checked Items Only:</th>
<th>Reason Medicare May Not Pay:</th>
<th>Estimated Cost:</th>
</tr>
</thead>
</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

**Options:** Check only one box. We cannot choose a box for you.

<table>
<thead>
<tr>
<th>OPTION 1.</th>
<th>OPTION 2.</th>
<th>OPTION 3.</th>
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<tr>
<td>I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</td>
<td>I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.</td>
<td>I don’t want the _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</td>
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</table>

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signature:  
Date:  

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
PATIENT PRE-ANESTHESIA QUESTIONNAIRE

Name of Patient: ___________________________ Age: ___________ Weight: ___________ Height: ___________

Date of Procedure: ___________________________ Procedure: ___________________________ Doctor: ___________________________

Person to drive you home: ___________________________ Telephone Number: ___________________________

Instructions: Please indicate if you have or have had any of the following. If you do not understand any question or are unsure of the answer, place a question mark next to the question.

1. Are you allergic to any medications? __Yes__ __No__
   Please list: ___________________________

2. Do you or have you ever smoked? __Yes__ __No__
   How much? ___________________________

3. Do you or have you used any recreational or “street drugs?” __Yes__ __No__

4. Do you drink alcohol? __Yes__ __No__
   How much? ___________________________

5. Could you be pregnant? __Yes__ __No__

6. Have you had a blood transfusion? __Yes__ __No__

7. Asthma or wheezing? __Yes__ __No__

8. Any other breathing or lung problems? __Yes__ __No__

9. High blood pressure? __Yes__ __No__

10. Is pain one of the reasons you are here today? __Yes__ __No__

11. If yes, where is your pain? __________________

12. How long have you had your pain? ____________

13. Heart attack? __Yes__ __No__

14. Angina or chest pain? __Yes__ __No__

15. Irregular heart beat? __Yes__ __No__

16. Any other heart problems? __Yes__ __No__

17. Liver problems or hepatitis? __Yes__ __No__

18. Kidney problems? __Yes__ __No__

19. Diabetes or high blood sugar? __Yes__ __No__

20. Epilepsy or seizures? __Yes__ __No__

21. Stroke, paralysis, meningitis? __Yes__ __No__

22. HIV or AIDS? __Yes__ __No__

23. Blood disease or bleeding problems? __Yes__ __No__

24. Sickle cell disease? __Yes__ __No__

25. Have you or a blood relative ever had any problems with an anesthetic? __Yes__ __No__

26. Can you climb a flight of stairs quickly or Walk 4 miles in an hour? __Yes__ __No__

List any operations you have had, along with the date of each: ____________________________________________________________
___________________________________________________________________________________________________
____________________________________________________________________________________________________________
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Additional comments or concerns about your health not covered above:

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Signature of patient or person completing form ___________________________ Date ____________ Time ____________

Reviewed by Anesthesiologist/P.A ___________________________ Date ____________ Time ____________
ACKNOWLEDGEMENT OF NEED FOR ESCORT AT TIME OF DISCHARGE FROM AMBULATORY SURGERY UNIT

I, _______________________________ acknowledge that I have been informed in advance, of my appointment for ambulatory surgery, that another adult must escort me home at the time of discharge. I understand that I will be discharged once I have recovered sufficiently from anesthesia and surgery to travel, but that I have a responsible adult to escort me home. This precaution is necessary because occasionally patients experience problems even though they have been medically stable prior to discharge. Accordingly, I have made, or will make, arrangements for another adult to escort me when I am discharged from the ambulatory surgery center.

SIGNED: __________________________ PRINT __________________________
PATIENT

DATE: ___________________________ TIME: __________________________

SIGNED: __________________________
WITNESS

DATE: ___________________________ TIME: __________________________
GREATER NEW YORK ENDOSCOPY SURGICAL CENTER
POLICY ON ADVANCED DIRECTIVES LIVING WILL
AND
DO NOT RESUSCITATE (DNR)

Do you have *Advanced Directives?   YES [ ]   NO [ ]

If you answered YES Please Read and Sign Below

Due to the ambulatory nature of your procedure and of this facility, we will not honor Advanced Directives, Living wills or Do Not Resuscitate orders for the short time that you are here as a patient. If you wish to maintain your status during your procedure, then you will have the option of having the procedure done in another facility that accepts this status. In signing this form you are agreeing to the postponement of your directives until you leave the facility.

_________________________________________  __________________________
Patient’s Signature or Legal Guardian     Date

____________________________________
Print Patient’s Name

____________________________________  __________________________
Witness (Sign and Print)     Date

* What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on.