GASTROCARE, P.C.

A.B. REDDY, M.D., F.A.C.G. REKHA KHURANA, M.D. SUBHASH BAJAJ, M.D.

Referring Physician: ______________________________

First Name: ____________________ **Last name:** ____________________

Date of Birth: ____________________ **Age:** ____________________

Pharmacy Name and Location: ____________________ **Pharmacy Fax Number:** ____________________

Your Email Address: ______________________________

Gender: Male Female

Race: American Indian / Alaskan Native / Asian / African American / Caucasian / More than one race / Pacific Islander / Declined

Ethnicity: Hispanic / Latino / Non-Hispanic / Declined

Language: English / Spanish / Other

Contact Preference: Home #: ____________ Cell #: ____________ Office #: ____________

REASON FOR VISIT: ______________________________

Allergies & Reactions: ______________________________

Current Medications (Name/Dose/How taken): ______________________________

Diagnostic Studies/Tests: ______________________________

Pneumococcal Vaccine: Yes / No Date: ________

Flu Vaccine: Yes / No Date: ________

Past or Present Medical Conditions:

Condition			
Cancer:	Yes	No	Type:________
Peptic Ulcer:	Yes	No	
Heart Attack:	Yes	No	
Diabetes:	Yes	No	
High Blood Pressure:	Yes	No	
Hepatitis:	Yes	No	Type:________
Stroke:	Yes	No	
Emphysema:	Yes	No	
Seizures:	Yes	No	
Colon Polyps:	Yes	No	
Ulcerative Colitis	Yes	No	
Irritable Bowel Syndrome	Yes	No	
Crohn's:	Yes	No	
HIV:	Yes	No	
Thyroid Problems:	Yes	No	
Sleep Apnea:	Yes	No	
Blood Clots:	Yes	No	
Pace Maker:	Yes	No	
Defibrillator	Yes	No	

Other Medical Conditions:________________

Gastrointestinal Symptoms:

Symptom		
None:	Yes	No
Black Stool:	Yes	No
Difficulty Swallowing:	Yes	No
Loss of appetite:	Yes	No
Abdominal Pain:	Yes	No
Abdominal Swelling:	Yes	No
Change in bowel habits:	Yes	No
Constipation:	Yes	No
Diarrhea:	Yes	No
Gas:	Yes	No
Heartburn/reflux:	Yes	No
Jaundice:	Yes	No
Nausea:	Yes	No
Rectal bleeding/blood in stool:	Yes	No
Stomach Cramps:	Yes	No
Vomiting:	Yes	No
Blood in vomit:	Yes	No
Weight Loss:	Yes	No

Review of Systems:

Allergic/Immunologic:

HIV exposure	Yes	No
strong allergic reactions	Yes	No

Cardiovascular:

chest pain	Yes	No
dyspnea with exercise	Yes	No
irregular heart beat	Yes	No
palpitations	Yes	No
orthophea	Yes	No
peripheral edema	Yes	No
syncope	Yes	No

Constitutional:

fatigue	Yes	No
fever	Yes	No
loss of appetite	Yes	No
weight loss	Yes	No

ENMT:

ear pain	Yes	No
nose bleeds	Yes	No
photophobia	Yes	No
sore throat	Yes	No
difficulty swallowing	Yes	No
loss of vision	Yes	No

Endocrine:

excessive thirst	Yes	No
hair loss	Yes	No
heat intolerance	Yes	No
diabetes	Yes	No

Genitourinary:

frequent urination	Yes	No
hematuria	Yes	No
difficulty urinating	Yes	No
blood in urine	Yes	No
kidney stone	Yes	No
endometriosis	Yes	No

Hematologic/Lymphatic:

easy bruising	Yes	No
prolonged bleeding	Yes	No

Integumentary:

allergies	Yes	No
dryness	Yes	No
hives	Yes	No
jaundice	Yes	No
rashes	Yes	No

Musculoskeletal:

arthritis	Yes	No
lupus	Yes	No
fibromyalgia	Yes	No

Neurological:

dizziness	Yes	No
fainting	Yes	No
frequent headaches	Yes	No
migraines	Yes	No
seizures	Yes	No

Psychiatric:

anxiety	Yes	No
depression	Yes	No
difficulty sleeping	Yes	No
nervousness	Yes	No
panic attacks	Yes	No
stress factors	Yes	No

Respiratory:

asthma	Yes	No
cough	Yes	No
dyspnea	Yes	No
shortness of breath (w/ exercise)	Yes	No
wheezing	Yes	No

Previous Colonoscopies (Date): ____________________

Previous EGDs (Date): ____________________

Previous Surgeries (Date): ____________________

____

Social History:

Occupation: ____________________

Marital Status: Single / Married / Divorced / Widowed

Alcohol: None | Duration:________ Type:__________ Quantity: __________ Frequency: __________

Caffeine: None | Duration:________ Type:__________ Quantity: __________ Frequency: __________

Tobacco: Current Every Day Smoker / Former Smoker / Never Smoked / Chew Tobacco

Quantity: __________ How long: __________

Recreational Drug Use: Never / In Past / Current Use If yes, type: ____________________

Family Medical History: Family history noncontributory Yes No

			Relationship:	**Type:**
Peptic Ulcer	Yes	No		
Colon Polyps	Yes	No		
Colon Cancer	Yes	No		
Stomach Cancer	Yes	No		
Esophageal Cancer	Yes	No		
Irritable Bowel Disease	Yes	No		
Ulcerative Colitis	Yes	No		
Crohn's	Yes	No		
Liver Disease/Cirrhosis	Yes	No		
Other Cancers, type	Yes	No		

GASTROCARE P.C. / TUSCALOOSA ENDOSCOPY CENTER

PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

REFERRING PHYSICIAN INFORMATION

Referring Physician: ______________________ City: ______________________
First Last

Primary Care Physician: ______________________ City: ______________________
First Last

Did you bring with you today the written referral from your Referring Physician? ☐ Yes ☐ No

PATIENT INFORMATION

Patient's Social Security #: ______________ Date of Birth: ______________ Gender: ☐M ☐F

Name of Patient: ____
First Middle Last

Street Address: ____

City: ______________ State: ________ Zip: ________ County: ________

Home Phone: (___) ________ Cell Phone: (___) ________ Work Phone: (___) ________

Employer: ____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Responsible Party: ____
(If different from patient) First Middle Last

Social Security #: ______________ Date of Birth: ______________ Gender: ☐M ☐F

Street Address: ____

City: ______________ State: ________ Zip: ________ County: ________

Home Phone: (___) ________ Cell Phone: (___) ________ Work Phone: (___) ________

Employer: ____

EMERGENCY CONTACT INFORMATION

Name: ____
First Middle Last

Relationship to patient: ______________________

Street Address: ____

City: ______________ State: ________ Zip: ________ County: ________

Home Phone: (___) ________ Cell Phone: (___) ________ Work Phone: (___) ________

GASTROCARE P.C. / TUSCALOOSA ENDOSCOPY CENTER

PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

INSURANCE COVERAGE PRIMARY

Please present your insurance card(s) and Driver's License during check-in

Name of Insurance: ______________________ Group Name: ______________________

Patient's Relationship to Policyholder: ☐Self ☐Child ☐Spouse ☐Guardian ☐Other

Name of Policyholder: ____

Date of Birth of Policyholder: ______________ Employer of Policyholder: ______________________

INSURANCE COVERAGE SECONDARY

Please present your insurance card(s) and Driver's License during check-in

Name of Insurance: ______________________ Group Name: ______________________

Patient's Relationship to Policyholder: ☐Self ☐Child ☐Spouse ☐Guardian ☐Other

Name of Policyholder: ____

Date of Birth of Policyholder: ______________ Employer of Policyholder: ______________________

I/ We hereby authorize GastroCare P.C. / Tuscaloosa Endoscopy Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient.

I/We authorize payment of medical benefits to GastroCare P.C. / Tuscaloosa Endoscopy Center.

I/We understand that should my account have to be referred to an attorney for collection that I/We are responsible for all fees and costs incurred therein.

I/We hereby authorize GastroCare P.C. / Tuscaloosa Endoscopy Center to act on my behalf in accessing hospital records when and if needed.

______________________ ______________________

Date Patient or Responsible Party

GASTROCARE, P.C.

and

TUSCALOOSA ENDOSCOPY CENTER

AUTHORIZATION FOR TREATMENT

The undersigned gives consent for the treatment considered necessary for the patient whose name appears on the bottom and that the treatment and procedures will be performed by the above practice physician, and whomever he may designate as assistants. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance is made as to the results that may be obtained.

Printed Name of Patient ______________________ Date ______________

Signature of Patient or Authorized Person ______________________ Witness ______________

Relationship to Patient ______________________

****

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to release to the Primary or Consulting / referring Physician such information as may be necessary for the completion of my hospitalization claims.

Signature of Patient or Authorized Person ______________________ Relationship to Patient ______________

****

AUTHORIZATION TO PAY THE PHYSICIAN / FACILITY

I hereby authorize payment for services provided in the office, endoscopy center and the hospital directly to the above physician, otherwise payable to me. I understand I am fully responsible for the medical and / or physician charges not covered by this authorization.

Signature of Patient or Authorized Person ______________________ Relationship to Patient ______________

****

PRIVACY POLICY RECEIPT

I have received, read, and understand the notice of the Privacy Policies.

Signature of Patient or Authorized Person ______________________ Relationship to Patient ______________

****

All authorizations must be signed by the patient or by an authorized person in the case of a minor or when a patient is physically or mentally incapable.

GASTROCARE, P.C. (GRC) AND
TUSCALOOSA ENDOSCOPY CENTER (TEC)

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER, it's physician's, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

_________ Spouse Name ______________________________

_________ Parent(s) Name(s) ______________________________

_________ Children Name(s) ______________________________

_________ Other Name(s) ______________________________

May we leave medical information on you answering machine? YES / NO

May we release medical information to an individual about your procedure, if they come with you for a procedure? YES / NO

Patient Signature: ______________________________ Date: _______________

******* _____________ DO NOT DISCUSS OR RELEASE ANY OF MY MEDICAL INFORMATION TO ANYONE EXCEPT MYSELF.

ACKNOWLEDGMENT & CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from GASTROCARE, P.C. (GRC) / TUSCALOOSA ENDOSCOPY CENTER (TEC). You agree that records concerning your care within GRC and/or TEC shall remain the property of TEC and/or GRC. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient; (2) payment for your services – billing, claims management, medical data processing, reimbursement, and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, medical research and educational purposes. You acknowledge that you have been provided with a GRC/TEC Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand GRC/TEC reserves the right to change the Notice and GRC/TEC will provide you with a revised Notice when you come to TEC/GRC. You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: ______________________________

TEC/GRC: Agree ____________ Do Not Agree ____________

______________________________ ______________________

Signature of Patient Date

Tuscaloosa Endoscopy Center

Date ____________________ Chart Number____________________

1. I ____ have received a copy of my rights and responsibilities and contact information regarding where and whom I may be able to express my concerns, complaints , and or grievances to. Any questions, and/or concerns will be my responsibility to bring it to the attention of the appropriate staff. **Initials**______

2. Because of the nature of our center and because each procedure is elective, it is the policy of Tuscaloosa Endoscopy Center to not honor Advance Directives. If you have an advance directives please bring it with you on the day of the procedure so we may have it for our records. Information on advance directives can be obtained from www.advdir.com. Any questions, concerns and/or disagreements to these terms will be my responsibility to bring it to the attention of appropriate staff.

I have an advance directive **Yes** _______ **No** _______
If yes, did you bring a copy with you today? **Yes** _______ **No** _______ **Initials**______

3. I have been given information about the organization's ownership. Any questions, and/or concerns will be my responsibility to bring it to the attention of the appropriate staff. Initials______

4. I have been given information about the organization's complaints and Grievances procedure. Any questions, and / or concerns will be my responsibility to bring it to the attention of the appropriate staff. **Initials**______

5. I have received written documentations of the items listed above, prior to my scheduled initial consultation and / or my procedure date. By signing below, I state my understanding and agreement to the above documents, in regards to Tuscaloosa Endoscopy center policies and procedures. I am validating that each initials next to the corresponding documents listed above were written by me. Furthermore, I have understood that should I have any questions regarding its content I should contact appropriate management or staff for clarifications.

____

Patient Signature

________________________________ ________________________________

Witness Signature **Witness Name**

Tuscaloosa Endoscopy Center

Dear Patient,

Our staff sincerely, hopes that your visit with us is pleasant and that we meet your expectations. If you have not received one of our procedure information brochures, you may pick up one in our waiting area or ask one of our receptionist.

The Center was established and built by Dr. Adisesha B. Reddy to serve his patients more effectively, and he remains the owner of Tuscaloosa Endoscopy Center. It is part of our Vision and Philosophy to provide you with high quality efficient outpatient surgical services. As part of that Vision and Philosophy we request that you, share any concerns or compliments that affect your care here at the center. Each compliment or concern will be followed up in a timely manner.

Because of the nature of our center and because each procedure is elective, regardless of an Advance directive formulated by a patient it is the policy of Tuscaloosa Endoscopy Center to resuscitate and transfer patients to a near by hospital.

Please contact us at 205 345 0012 if you have any questions regarding your insurance or financial arrangements prior to your procedure.

Again the employees of Tuscaloosa Endoscopy Center thank you for allowing us to serve your Endoscopy needs.

Sincerely,

Tuscaloosa Endoscopy Center

GASTROENTEROLOGY CONSULTANTS OF TUSCALOOSA INC [GECT]
TUSCALOOSA ENDOSCOPY CENTER[TEC]
GASTRO CARE PC [GRC]
100 Rice Mine Rd. N– Suite E
Tuscaloosa, AL 35406
205-345-0010 (P) – 205-752-1175 (F)

NOTICE OF PRIVACY PRACTICES

(This information is made available to all patients)

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.

WHO WILL FOLLOW THIS NOTICE:

Any health care professional authorized to enter information into your chart (including physicians, PA's, RN's, CRNP's);
All areas of the practice (front desk, administration, billing and collection etc);
All employees, staff and other personnel that work for or with our practice;
Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, etc.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting the privacy of this information. We create a record of the care and services you receive at GECT/TEC/GRC. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by GECT/TEC/GRC, whether made by GECT/TEC/GRC personnel or your physician.
This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of the notice that is currently in effect at the time Private Health Information was obtained.

FACILITY RESPONSIBILITIES
HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other GECT/TEC /GRC personnel who are involved in taking care of you at GECT/TEC/GRC.

For Payment: We may use and disclose medical information about you so the treatment and services you receive at GECT/TEC/GRC may be billed to and payment collected from you, an insurance company or a third party. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan.

For Health Care Operations. We may use and disclose medical information about you for GECT/TEC/GRC operations. These uses and disclosures are necessary to operate GECT/TEC/GRC and make sure all of our patients receive quality care. Some of the operations may include:

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at GECT/TEC/GRC.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you have been seen at GECT. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person. Such disclosure would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries.

Public Health Risks: We may disclose medical information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to allow you to obtain an order protecting the information requested.

Law Enforcement: We may disclose medical information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at GECT/TEC/GRC/AMC.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Home Directors: We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of GECT/TEC/GRC to funeral home directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the correctional institution or the law enforcement official. This would be necessary for the institution to provide you with health care, to protect your health and safety of others or for the safety and security of the correctional institution.

Other Uses: Any other uses or disclosures of your health information will be made only with your written authorization.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

- **Right to Inspect and obtain a copy of your health information** as provided in 45 C.F.R. 164.524. This does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the PRIVACY OFFICER. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by GECT/TEC/GRC/ will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

- **Right to amend your health information** as provided in 45 C.F.R. 164.526. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by GECT/TEC/GRC. To request an amendment, your request must be in writing and submitted to the PRIVACY OFFICER. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us.
  - Is not part of the information kept by GECT/TEC/GRC
  - Is not part of the information which you would be permitted to inspect and copy.
  - Is accurate and complete.

- **Right to obtain an Accounting of Disclosures** as provided in 45 C.F.R. 164.528. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for reasons other than Treatment, Payment or Operations. To request this list of accounting, you must submit your request in writing to the PRIVACY OFFICER.

  Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions** on certain uses and disclosures of your health information as provided by 45 C.F.R. 164.552. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information

- we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

  WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST: If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you

must make your request in writing to the PRIVACY OFFICER. In your request, you must tell us what information you want to limit, whether you want us to limit our use, disclosure or both and to whom you want the limits to apply.

- **Right to Request Confidential Communications** as provided in 45 C.F.R. 164.522 (b): you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or at work and not at home. To request confidential communications, you must make your request in writing to the PRIVACY OFFICER. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in GECT./TEC/GRC The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or admitted to GECT/TEC/GRC for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our Practice Administrator at 205 345 0181 or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact our administrator or DON at 205 345 0181, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and shall be investigated, without repercussion to you.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

TUSCALOOSA ENDOSCOPY CENTER

Patients and families are our number one concern. It is a priority at the Tuscaloosa Endoscopy Center that patients and families are as comfortable as possible during their stay at the center. The following patient rights and responsibilities are presented as a policy for the Tuscaloosa Endoscopy Center but do not presume to be a complete representation of all mutual rights and responsibilities.

Patients Have The Rights

- To reasonable access to the medical resources at the Tuscaloosa Endoscopy Center without regard to race, color, national origin, age, sex, disability, or financial status.
- To receive considerate, respectful, compassionate care that recognizes your personal values and beliefs.
- To be informed about and to participate in decisions regarding your care, including the refusal of treatment.
- To be involved in all aspects of care and to be allowed to participate in the care and to designate another person to act in your behalf.
- To voice complaints about your care and to have those complaints reviewed and, when possible, resolved. **You have the right to voice your complaint to any representative of the Center or directly to the administrator or the Director of Nursing (205 345 0012).** You also have the right to contact the Alabama Department of Public Health at (800) 356-9596 or at their website, www.adph.org, or the Medicare Ombudsman at the Alabama State Health Insurance Assistance Program or by telephone at (800) 633-4227 or www.cms.gov/center/ombudsman.asp.
- To receive care in a safe environment
- To information about Advance Directives that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- **However, regardless of an Advance Directive formulated by a patient, it is the policy of the Tuscaloosa Endoscopy Center to resuscitate and transfer patients to a nearby hospital. Any patient who presents an Advance Directive or who indicates a desire to prepare an Advance Directive will be informed of this policy and, if requested, provided with available literature.**
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your action.
- To have clinical and educational information about your treatment in language and terms that you understand.
- To change their provider if other qualified providers are available.
- To information about any research activities that involve your treatment, including benefits and risks, procedures involved, and alternative treatments.
- To get a copy of your medical records in paper or electronic format.
- To correct your medical record.
- Get a copy of this privacy notice.
- To choose someone to represent you.
- To security, privacy, and confidentiality in all patient areas as you undergo discussion, tests or treatment.
- Ask us to limit the information we share and get a list of whom we share your information with.
- To know who is responsible for providing your immediate direct care.
- To information about the financial aspects of services and alternative choices.
- To be supported in accessing protective services when requested.
- To have your pain assessed, reassessed and be involved in the decisions about managing your pain.
- Get a list of those with whom we have shared your information.

Patients Have The Responsibilities

- To provide complete and accurate information including your full name, address, phone number, date of birth, insurance carrier and employer when required
- To give your doctor and the surgery center staff complete and accurate information about your condition and care, including the reporting of unexpected changes in your condition to your physician and nurse.
- To advise your nurse, physician, or other caregiver if you do not understand the treatment course or decisions about your care.
- To follow the orders and instructions given by your doctor and instructions given by the staff for your care, including keeping follow-up appointments after discharge.
- You are expected to ask questions if you do not understand information or care
- You are responsible for outcomes if you do not follow the treatment plans.
- To show consideration for other patients by following all rules and instruction pertaining to smoking, visitors, noise, and general conduct.
- To accept the financial obligations associated with your care.
- To be considerate of staff members who are caring for you. A mutual spirit of respect and cooperation allows us to serve you best.
- To provide a responsible adult to remain with the patient while in the facility and to transport him or her home and a responsible adult to remain with him or her

Tuscaloosa Endoscopy Center

Los pacientes y las familias son nuestra unica interes. Es una prioridad en el Centro de endoscopy de Tuscaloosa que pacientes y familias esten lo mas comodo possible durante su etancia en el Centro. La declaracion siguiente de los derechos del paciente y las responsabilidades son presentadas como una politica para el Centro de endoscopy de Tuscaloosa, pero no presumen de ser una reresentacion completa de todos los derechos y responsabilidades mutuos.

los pacientes tienen el derecho

- Al accesso rasonable a los recursos medicos en el Centro de endoscopy de Tuscaloosa sin consideracion de raza, color, origen nacional, edad, sexo, discapacidad o situacion financiera.
- A considerar, respetuosa y compasivo cuidado que reconoce sus valores y creencias personales.
- Para ser informado y a participar en las decisiones sobre su cuidado incluyendo el rechazo al tratamienta.
- Para participar en todos los aspectos de cuidado y a participar en el cuidado y disignar a otro persona para actuar en su nombre.
- Para informacion acerca de directives advanzada que le permite reformar sus propias decisiones de salud para el futuro y que su representante escojido ejercite los derechos par usted si usted no puede hacerlo.

  Sin embargo, independentemente de cualquier directiva avanzada formulada por un paciente, es ploitica del centro de cirugia de Tuscaloosa de resucitar y transportar al paciente al hospital mas cerca. Cualquier paciente que presente un avanzado directiva o pue indique desiar preparar un avanzado directiva sera informado de esta politica y como apropiado, la literatura disponible proporcionado.

- A negarse al tratamiento hasta el punto permitido por la ley y para ser informado de las consecuencias médicas de su acción.
- A informacion clinico y educacional acerca de su tratamiento en el idioma y condiciones que entiende.
- Para expresar quejas acerea de su cuidado, y para tener esas que jas revisadas y cuando posible resuelto. Tiene el derecho de expresar su queja a cualquier representante del centro directamente al administrador. Tambien tiene el derecho al contacto con el departamento de salud de Alabama al (800) 356-9596 ó al medicare ombudsman en el estado de Alabama

  www.adph.org

  seguro de salud programa de asistencia por telefono en 800-243-5463 o a

  www.cms.hhs.gov/center.ombudsman.asp

- Para tener acceso a comunicarse con dirigentes de organizacion si una etica, cultural o dilema espiritual se presenta a si misma.
- A la informatión sobre cualquier actividades de investigacion que implican su tratamiento incloyendo beneficios y riesgos, los procedimientos implicado y tratamientos alternativos.
- A la seguridad, privacidad y la confidencialidad en todas las areas de cuidado de los enfermos como experimentar examines o tratamiento.
- Para saber quien es responsable de praporcionar su inmediata atencion directa.
- Para cambiar su proveedor si otros proveedores calificados están disponibles.
- A la informacion sobre los aspectos financieros de servicios y elecciones alternativas.
- Ser apoyado a conseguir acceso a servicios protectores cuando sea solicitado.
- Para apropiar evaluacion de dolor y gestion de dolor. Mientras dolor puede ser una parte comun de la experiencia del paciente, dolor absoluto puede tener efectos adversos, efectos fisicos y psicologicos.
- Todas los pacientes seran evaluados para el dolor en la admission y a traves de su estancia.
- Pacientes no deben vacilar en pedir medicina para aliviar dolor cuando empieza primero o aumenta.

los pacientes tienen la responsabilidad

- Par dar a su medico y el centro de la cirugia informacion completa y exacta sobre su condicion y el cuidado, incluyendo la cobertura de cambios inesperados en su condicion a su medico y la enfermera.
- Para aconsejar a su enfermera, el medico o otro cuidador si usted no comprende el curso del tratamiento o decisiones acerca de su cuidado.
- Para seguir las ordenes y las instrucciones dadas por su medico e instrucciones dadas por el personal para su cuidado, incluyendamantener revisiones despues de descarga.
- Para reportar cambios inesperados en su condicion a su medico y la enfermera
- Para mostrar consideracion para otros pacientes siguiendo todas las reglas y las instrucciones que pertenecen al fumar, los visitantes, el ruido y conducta general.
- Para aceptar las obligaciones financieras asociadas con su cuidado.
- Para ser conciderado de empleados que cuidan de usted. Un espiritu mutuo de respeto y cooperacion nos permite servirle mejor.
- Para aconsejar a su enfermera, el medico, el cuidador y/o el personal administrative del negocio de cualquier descontento que usted puede tener con respecto a su cuidado.
- De proporcionar un adulto responsable y permanecer con el paciente mientras este en las instalaciones y para el transporte de él o ella a su casa.
- De proporcionar un adulto responsable para permanecer con él o ella las (24) horas, si es requerido por su proveedor de él o ella.