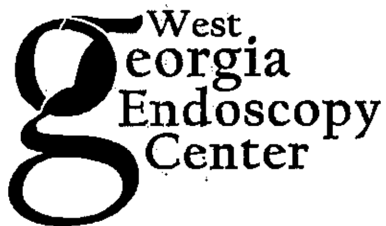

Bremen/Carrollton
770.214.2800
Newnan
770.251.5559
Fax
770.214.2803

Dear Patient,

Welcome to West Georgia Endoscopy Center! We appreciate and respect the confidence you have placed in us by choosing our physicians and facility for your care.

Please complete the attached forms prior to your arrival at the Endoscopy Center.

Thank you for giving us the opportunity to take care of your healthcare needs. We look forward to seeing you.

Sincerely,

The Providers and Staff of West Georgia Endoscopy Center, LLC.

Carrollton
160 Clinic Avenue
Carrollton, GA 30117
www.westgagastro.com

The Doctors and Staff of West Georgia Endoscopy Center, LLC want you to know how we will protect your private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act("HIPPA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give Patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans, and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil and criminal penalties: and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosure to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any review and keep for your records. Thank you for your cooperation.

Acknowledge of receipt of Notice of Privacy Practices

Patient Name:____
(please print)

Signature of Patient or Personal Representative:

________________________________ Date: ______________

Persons to Whom Information may be disclosed

____
Name of Person/Relationship

____
Name of Person/Relstionship

WEST GEORGIA ENDOSCOPY CENTER, LLC

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The West Georgia Endoscopy Center, LLC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the *facility* has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA or HITECH privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, electronically or by facsimile.

A. **Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment.** Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the procedure. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services. We will not, however, disclose protected health information regarding treatments for which you have paid out-of-pocket in full.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the **WEST GEORGIA ENDOSCOPY CENTER, LLC** and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your procedure date, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspended Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you

are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection With Judicial And Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **For Research Purposes.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In the Event of a Serious Threat to Health or Safety.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions.** In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation.** The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your procedure or payment related to your procedure. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the facility uses for making decisions about you including health information from other providers.

   Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

   We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

   To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. You may request an electronic version of your medical information and this will be provided to you if it is readily producible. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. These will be made available to you within 30 days unless extenuating circumstances apply.

   Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

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VI. Our Duties

A. The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

B. The facility is required to notify you if/when your PHI has been compromised.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

WEST GEORGIA ENDOSCOPY CENTER, LLC
160 Clinic Avenue
Carrollton, GA 30117
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at 770-834-2225.

IX. Effective Date

This Notice is effective ____________________.

©Continuum Healthcare Consultants, Inc.

WEST GEORGIA ENDOSCOPY CENTER, LLC
PATIENT AUTHORIZATION FORM

I request that payment of authorized benefits be made to **WEST GEORGIA ENDOSCOPY CENTER, LLC.** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

DATE:____________________ **INITIALS:**________________

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process claims, and any other medical information that is required for any healthcare related utilization review or quality assurance activities, and to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **WEST GEORGIA ENDOSCOPY CENTER, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, and self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me or my financial responsibility for all medical fees and charges incurred by my or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **WEST GEORGIA ENDOSCOPY CENTER, LLC** by any insurance policy, self-insurance program, or other benefit plan.
This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION: ____

RELATIONSHIP TO PATIENT IF NOT PATIENT: ______________________________________

DATE: ______________________ **INITIALS:** _______________________

ALTERNATIVE CONTACT AUTHORIZATION

I do O do not O authorize **WEST GEORGIA ENDOSCOPY CENTER, LLC** to contact me or leave messages for me at my place of work. **DATE:** _____________ **INITIALS:** _______________

I do O do not O authorize **WEST GEORGIA ENDOSCOPY CENTER, LLC** to discuss my appointments, medical evaluation, treatment, and results with relatives or other persons as indicated:

Authorized person/relationship:

____

DATE: __________________ **INITIALS:** ____________________

I hereby authorize WEST GEORGIA ENDOSCOPY CENTER, LLC to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize that I must call the office to obtain laboratory results.
DATE: _______________ **INITIALS:** __________________

ADVANCE DIRECTIVES

I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. Also, I acknowledge that I do O or do not O have such Advance Directives. I acknowledge West Georgia Endoscopy Center, LLC does not honor the Do not Resuscitate portion of my Advance Directives, but will incorporate it into the medical record if I provide a copy.
DATE: _____________ **INITIALS:** _______________

WEST GEORGIA ENDOSCOPY CENTER, LLC
PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

1. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration, and dignity.
2. Patients shall receive assistance in a prompt, courteous, and responsible manner.
3. Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
4. Patients have the right to know the identity and status of individuals providing services to them.
5. Patients have the right to change providers if they so choose.
6. Patients, or legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if know, and follow-up care. All patients will sign an informed consent from after all information has been provided and their questions have been answered.
7. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
8. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
9. Patients have the right to express complaints about the care they have received and to submit their grievance to the Clinical Supervisor. The Clinical Supervisor will complete an "Adverse Event Notification" and bring the issue to the attention of the Medical Director in a timely manner, so that the grievance may be addressed. West Georgia Endoscopy Center is responsible for providing the patient or his/her designee with a written response within 30 days, indicating the findings of the investigation.
10. Patients have the right to be provided with information regarding emergency and after hours care.
11. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient
12. Patients have the right to a safe and pleasant environment during their stay
13. Patients have the right to have procedures performed in the most painless way possible.
14. Patients have the right to develop Advance Directives, however, West Georgia Endoscopy Center LLC, does not honor Advanced Directives.
15. Patients have the right to be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payments.
16. Patients have the right to approve or refuse the release or disclosure of his/her medical record to a healthcare facility, except as required by law or third party payment contract.
17. Patients have the right to be informed that West Georgia Endoscopy Center is owned and operated by Howard Seeman, MD and John Arledge, MD
18. Patients have the right to exercise his or her rights without being subjected to discrimination or reprisal.
19. Patients have the right to be free from all forms of abuse or harassment.

Patient Responsibilities

1. Patients are responsible for providing complete and accurate medical histories, including providing information on all current medications.
2. Patients are responsible for providing an adult to transport them home after the procedure.
3. Patients are responsible for keeping all scheduled pre-and post-procedure appointments, and complying with treatment plans to help ensure appropriate care.
4. Patients are responsible for reviewing and understanding the information provided by the Physician or Nurse.
5. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
6. Patients are responsible for providing insurance information at the time of their visits, and notifying

the receptionist of any changes in insurance coverage or medical information.

7. Patients are responsible for paying all charges for co-payments, co-insurance, and deductibles on non-covered services at the time of the visit, unless other arrangements have been made in advance.
8. Patients are responsible for treating physicians and staff in a courteous and respectful manner.
9. Patients are responsible for asking questions about their medical care and seeking clarification from the physician of the services to be provided, until they fully understand the care they are to receive.
10. Patients are responsible for following the advice of their provider, and understanding the alternatives and/or likely consequences if they refuse to comply.

Signature:______________________________________ Date:_____________________

To file a grievance you may contact:

Jim Cooley, Administrator @ 770-214-2800

Georgia Department of Community Health
Office of Health Care Facility Regulation Division
2 Peachtree St.
Atlanta, GA 30303
1-800-878-6442

CMS Office of Inspector General
1-800-447-8477

Office of Medicare Beneficiary Ombudsman
http://www.cms.hhs.gov/center/ombudsman.asp
1-800-633-4227

<u>Notices to Patients Concerning Pathology Billing</u>

During your procedure a tissue specimen(s) may be taken and sent to our Pathology provider, *Miraca Life Sciences*, for processing and diagnosis. If so, their services will result in your Insurance provider sending you an Explanation of Benefits (EOB).

An EOB is not a Bill

The only time you should pay Miraca Life Sciences is if you receive a bill or statement from them.

Miraca Life Sciences will treat your claim as In-network even if the EOB your Insurance provider sends you shows them as Out-of-network. If you have any questions, please contact Miraca's Billing department at 888-344-1160.

WGG
Anesthesia, LLC

For Questions about your Anesthesia Charges, please call 1.800.951.7850

Dear Patient:

Thank you for allowing AHP of West Georgia to provide the highest level of comprehensive anesthesia services for you. This letter is intended to inform you of our billing practices for the services you have received. There are multiple billing components, such as the professional services of the surgeon, the professional services of the anesthesiologist/anesthetist, professional services of the pathologist, drugs/supplies, and the use of the facility services/equipment.

Billing. As a courtesy, we will bill your primary and/or secondary insurance company for your anesthesia services and make every effort to get our charges paid. However, if your insurance company deems the anesthesia charge(s) or the services of the anesthesiologist/anesthetist not medically necessary or non-covered, you will be billed at our current self-pay rate.

- If we are *out of network* with your insurance carrier, the payment and EOB (Explanation of Benefits) for our services may be sent to you. Please endorse the insurance payment or send a personal check with the EOB of total amount to the address listed below. As a non-participating provider, we are unable to determine the payment your carrier will make, thus we are unable to accurately quote an estimated patient responsible portion. As soon as the EOB is received, we will be able to make the determination. AHP of West Georgia will make every effort to collect all the payments directly from your insurance company.

- For all *In network* carriers we will receive payment with (EOB). In addition, you will be responsible for paying the co-pays and deductibles in accordance with your insurance carrier contract.

- Patients with no insurance coverage will be billed at the current self-pay rate. If you wish to pay for services and not submit a claim to your insurance carrier, please contact our office to discuss possible debt that may be incurred. Please note: you will be responsible for the amount the carrier would have paid if the claim had been filed. If you are deemed indigent by your State Authority, please provide a copy of the letter to our office.

If you have any questions concerning your bill for the procedure(s) you are having, please contact our billing office, toll-free at:

1.800.951.7850

Please mail payments, Explanation of Benefits, correspondence, etc to:

WGG Anesthesia, LLC
P.O. Box 4860
Murrells Inlet, SC 29576-2698