West Georgia Endoscopy Center

Bremen/ Carrollton/ Wedowee/Endoscopy Center
770-214-2800
Villa Rica
770-456-3786

Dear Patient,

Welcome to West Georgia Endoscopy Center! We appreciate and respect your confidence in us, as you have chosen our physicians and facility for your care.

Please complete the attached forms before you arrive at the Endoscopy Center.

Thank you for allowing us to take care of your healthcare needs. We look forward to serving you.

Sincerely,

The staff of West Georgia Endoscopy Center

John Arledge, MD

Thelma Lucas, MD

Prashant Sharma, MD

Peter Ojuro, DO

Edward Pisoh, MD

West Georgia Endoscopy Center

West Georgia Endoscopy Center
Notice of Privacy Practices
Effective Date: 4/3/2024

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Access This Information. Please Review It Carefully.

Our Commitment to Your Privacy

West Georgia Endoscopy Center is committed to protecting the privacy of your health information. This Notice of Privacy Practices is designed to inform you how we use and protect your medical information. We are required by law to maintain your health information's privacy and provide you with this notice of our legal duties and privacy practices concerning it.

Uses and Disclosures of Health Information

We may use and disclose your health information in the following ways:

1. **Treatment**: We may use or disclose your health information to provide, coordinate, or manage your healthcare and related services.
2. **Payment**: We may use and disclose your health information to obtain payment for our services.
3. **Healthcare Operations**: We may use or disclose your health information for activities necessary to run our practice, such as quality assessment, case management, and training programs.
4. **Required by Law**: We may disclose your health information when required to do so by federal, state, or local law.
5. **Other Uses and Disclosures**: We may use or disclose your health information for public health purposes, to report abuse or neglect, for health oversight activities, to comply with judicial orders or subpoenas, for law enforcement purposes, or other uses permitted or required by law.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information:

1. **Right to Inspect and Copy**: You have the right to inspect and copy your health information.
2. **Right to Amend**: If you believe your health information needs to be corrected or completed, you can request an amendment.
3. **Right to an Accounting of Disclosures**: You have the right to request an accounting of disclosures we have made of your health information.
4.

West Georgia Endoscopy Center

5. **Right to Request Restrictions**: You have the right to request restrictions on how your health information is used or disclosed.
6. **Right to Confidential Communications**: You have the right to request that we communicate with you about your health information in a certain way or at a certain location.
7. **Right to a Paper Copy of This Notice**: You have the right to receive a paper copy of this Notice upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Contact Information

To exercise your rights or if you have any questions or concerns regarding this Notice, please contact:
David Bearden, Facility Coordinator

dbearden@westgaendoscopy.com

770-834-2225

Changes to This Notice

We reserve the right to change this Notice's terms and make the new notice provisions effective for all health information we maintain. We will post a copy of the revised Notice in our office and make it available upon request.

Signature of Acknowledgment
I acknowledge receipt of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

West Georgia Endoscopy Center

Notice of Privacy Practices
Effective Date: 01/28/2025

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.

Our Commitment to Your Privacy

West Georgia Endoscopy Center is committed to protecting the privacy and confidentiality of your health information. We are required by law to maintain the privacy of your health information and provide you with this Notice of our legal duties and privacy practices concerning your health information. We must also notify you of any significant changes to our privacy practices.

How We Use and Disclose Your Health Information

We may use and disclose your health information in the following ways:

1. **Treatment**
   We may use and disclose your health information to provide, coordinate, or manage your healthcare. For example, your information may be shared with your primary care physician or other healthcare providers involved in your care to ensure proper treatment, such as during a procedure or for follow-up care.
2. **Payment**
   We may use and disclose your health information to obtain payment for our services. For example, we may disclose information to your health insurance company to verify coverage, receive authorization for procedures, or process claims.
3. **Healthcare Operations**
   We may use and disclose your health information for operations necessary to run our practice, such as quality assessment, performance evaluations, and administrative tasks.
4. **Appointment Reminders**
   We may use your information to contact you to remind you about scheduled appointments and follow-up care or to inform you of any changes in your procedure schedule.
5. **Treatment Alternatives**
   We may use and disclose your health information to inform you about treatment options or alternatives.
6. **Health-Related Benefits and Services**
   We may use and disclose your health information to tell you about health-related benefits, services, and programs that interest you.
7. **Required by Law**
   We may disclose your health information when federal, state, or local law requires, including reporting certain communicable diseases or conditions as required by public health authorities.

8. **Public Health Activities**
   We may disclose your health information for public health activities like disease prevention, surveillance, and investigations. This may include reporting adverse reactions to medications or vaccines to the appropriate authorities.

9. **Legal and Regulatory Compliance**
   We may disclose your health information when required for law enforcement purposes, judicial or administrative proceedings, or other legal reasons, as authorized or required by law.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information:

1. **Right to Inspect and Copy**
   With certain exceptions, you have the right to inspect and obtain a copy of your health information that we maintain.

2. **Right to Amend**
   If you believe that your health information needs to be corrected or completed, you have the right to request an amendment to your health information.

3. **Right to an Accounting of Disclosures**
   You have the right to request an accounting of certain disclosures of your health information made by us for purposes other than treatment, payment, or healthcare operations.

4. **Right to Request Restrictions**
   You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations. However, we are not required to agree to your request.

5. **Right to Confidential Communications**
   You have the right to request that we communicate with you about your health information in a certain way or at a certain location (e.g., via mail, phone, or email). We will accommodate reasonable requests.

6. **Right to Receive a Paper Copy of This Notice**
   You have the right to request a paper copy of this Notice, even if you have agreed to receive it electronically.

How to Exercise Your Rights

To exercise any of the rights listed above or for more information about how your health information is used and disclosed, please get in touch with our office at:

West Georgia Endoscopy Center
Contact Information:
770-214-2800
dbearden@westgaendoscopy.com
160 Clinic Ave. Carrollton GA 30117 ATTN: David Bearden

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

United States Department of Health and Human Services
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Additionally, you may contact us at:

Toll-free: (800) 368-1019
TDD toll-free: (800) 537-7697

Changes to This Notice

We reserve the right to change this Notice's terms and make the new notice provisions effective for all health information we maintain. A revised notice will be available upon request and posted in our office.

West Georgia Endoscopy Center

WEST GEORGIA ENDOSCOPY CENTER, LLC

PATIENT AUTHORIZATION FORM

I request that authorized benefits be paid 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: _____ Signature: _____

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 in review or quality assurance activities, and to any healthcare professional requiring this information to treat me.

I hereby assign and authorize payments 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 me 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 I revoke it 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: _____ Signature: _____

West Georgia Endoscopy Center
160 Clinic Ave.
Carrollton, GA., 30117
www.westgagastro.com

West Georgia Endoscopy Center

ALTERNATIVE CONTACT AUTHORIZATION

I ☐do ☐I do not authorize WEST GEORGIA ENDOSCOPY CENTER, LLC, to contact me or leave messages at my place of work.

DATE: _____ Signature: _____

I ☐do ☐do not 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:

1._____

2._____

3._____

DATE: _____ Signature: _____

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

DATE: _____ Signature: _____

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 ☐do not have such Advance Directives. I acknowledge that 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: _____ Signature: _____

West Georgia Endoscopy Center
160 Clinic Ave.
Carrollton, GA., 30117
www.westgagastro.com

West Georgia Endoscopy Center

WEST GEORGIA ENDOSCOPY CENTER, LLC

PATIENT RIGHTS and 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 prompt, courteous, and responsible assistance.

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 legally authorized representatives, have the right to thorough, current, and understandable information regarding their diagnosis, treatment options, and prognosis, if known, and follow-up care. All patients will sign an informed consent form 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 providers.

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 before commencement.

9. Patients have the right to express complaints about their care and submit their grievances to the Clinical Supervisor. The Clinical Supervisor will complete an "Adverse Event Notification" and bring the issue to the attention of the Medical Director promptly so that the grievance may be addressed. West Georgia Endoscopy Center is responsible for

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providing the patient or their designee with a written response within 30 days indicating the investigation findings.

10. Patients have the right to receive emergency and after-hours care information.

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 advanced directives; however, West Georgia Endoscopy Center LLC does not honor the do not resuscitate portion of Advanced Directives.

15. Upon request, patients have the right to be provided with all available information regarding services at the Center and estimated fees and payment options.

16. Patients have the right to approve or refuse the release or disclosure of their medical records to a healthcare facility, except as required by law or third-party payment contracts.

17. Patients have the right to be informed that John Arledge, MD, Thelma Wiley-Lucas, MD, Prashant Sharma, MD, and Peter Ojuro, MD, have ownership in West Georgia Endoscopy Center.

18. Patients have the right to exercise their rights without discrimination or reprisal.

19. Patients have the right to be free from abuse or harassment.

Patient Responsibilities

1. Patients are responsible for providing complete and accurate medical histories and 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.

West Georgia Endoscopy Center

5. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.

6. Patients are responsible for providing insurance information during 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 visit unless other arrangements have been made in advance.

8. Patients are responsible for treating physicians and staff courteously and respectfully.

9. Patients are responsible for asking questions about their medical care and seeking clarification from the physician regarding the services to be provided until they fully understand the care they are to receive.

10. Patients are responsible for following their provider's advice and understanding the alternatives and/or likely consequences if they refuse to comply.

Signature:_____ Date:_____

To file a grievance, you may contact:

Tammy Horton, Administrator 770-214-2800

Georgia Department of Community Health

Office of Health Care Facility Regulation Division

17 th Floor

2 Martin Luther King Jr Dr SE

East Tower

Atlanta, GA 30303

1-800-878-6442

CMS Office of Inspector General1-800-447-8477

Office of Medicare Beneficiary Ombudsman

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

Notice to Patients Concerning Pathology Billing

During your procedure, your provider may take a tissue specimen(s), and we will send them to our partner laboratory for processing and diagnosis. If this happens, their services will result in your insurance provider sending you an Explanation of Benefits (EOB).

AN EOB IS NOT A BILL

Should insurance not cover part of the pathology expenses, you will receive a bill from the pathology provider. If you have any questions regarding the pathology portion of your procedure, please contact

AmeriPath Indianapolis, PC

3495 Hacks Cross Rd.

Memphis, TN 38125

866-697-8378

For Questions about your Anesthesia Charges, please call 1.800.951.7850

WGG
Anesthesia, LLC

Dear Patient:

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

- 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, suppose your insurance company deems the anesthesia charge(s) or the services of the anesthesiologist/anesthetist not medically necessary or non-covered. In that case, 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 of the total amount with the EOB to the address listed below. As a non-participating provider, we cannot determine your carrier's payment; thus, we cannot accurately quote an estimated patient-responsible portion. As soon as the EOB is received, we can make the determination. AHP of West Georgia will try 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 without insurance 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, don't hesitate to 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 get in touch with 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