Please review the attached Main Line Endoscopy Center Patient Registration forms. **COMPLETE** the highlighted forms and bring to the Endoscopy Center on the day of your procedure.

- □ Patient Rights & Notification of Ownership
- □ Notice of Privacy Practices
- □ Multiple Authorization Form
- □ Patient Medication Reconciliation Form

Please visit www.mainlineendoscopy.com for additional information regarding:

- Directions
- Admission and Discharge Process
- Covid 19 Screening Survey
- Prep Instructions

Do	Do Not	Mandatory
Bring insurance card/photo ID	Drink anything 4 hours prior to procedure	Driver must escort patient to and from Endoscopy suite
Bring completed forms	Chew gum/hard candy	Notify us with any insurance changes prior to procedure
Bring advance directive, if applicable	Drive for 12 hours after your procedure	Complete Covid 19 Screening Survey 24-48 hours prior to procedure (electronically sent)
Bring socks/slippers	Schedule a ride home with a Taxi, Uber or Lyft driver (Unless accompanied by a responsible adult, 18 years or older)	Call 610-644-6755 if you do not hear from the office regarding how to take your Blood Thinning medications 10 days prior to procedure
Bring Inhaler	Bring valuables	
Follow prep specific instructions		

Insurance coverage and/or out-of-pocket expenses may vary based on your diagnosis, place of service, or type of service being performed. Therefore, we strongly suggest that you contact your insurance company to determine if any personal expenses will be incurred for this service. You will be contacted by our Insurance Verification Specialist prior to your procedure if you have any upfront patient financial responsibility. Please feel free to contact our billing department at 215-723-2333, if you have any other insurance questions. If you have any questions regarding your procedure, please contact Main Line Gastroenterology at 610-644-6755.

Main Line Endoscopy Center, West
325 Central Ave
Lower Level
Malvern, PA 19355
610-644-7274

Main Line Endoscopy Center, East
Two Bala Plaza-Suite IL-30
333 E. City Line Ave
Bala Cynwyd, PA 19004
610-660-8470

Main Line Endoscopy Center, South
1088 W. Baltimore Pike
HCC II-Suite 2407
Media, PA 19063
610-229-9373

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

Every patient has the right to be treated as an individual and to actively participate in and make informed decisions regarding his/her care. The facility and medical staff have adopted the following list of patient's rights and responsibilities, which are communicated to each patient, or patient's representative/surrogate in advance of the procedure.

Patient Rights:

Every patient of a facility shall have the right:

a) To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

b) To receive considerate, respectful and dignified care.

c) To be provided privacy and security during the delivery of patient care service.

d) To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

e) To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

f) When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

g) To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.

h) To be free from mental and physical abuse, or exploitation during the course of patient care.

i) Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

j) Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

k) To have care delivered in a safe abuse environment, free from all forms of, neglect, harassment, or reprisal.

l) Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.

m) Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.

n) To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

o) To be informed of the right to change providers if one is available

p) To know which facility rules and policies apply to his/her conduct while a patient.

q) To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.

r) To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.

s) To examine and receive an explanation of his/her bill regardless of source of payment.

t) To appropriate assessment and management of pain.

u) To be advised if the physician providing care has a financial interest in the surgery center.

Patient Responsibilities:

▪To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

▪To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.

▪To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.

▪To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.

▪To accept personal financial responsibility for any charges not covered by their insurance.

▪ To be respectful of all the healthcare professional and staff as well as other patients.

If you need an Interpreter:

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Main Line Endoscopy Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Main Line Endoscopy Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Main Line Endoscopy Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Main Line Endoscopy Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Rights and Respect for Property and Person:

The patient has the right to:

•Exercise his or her rights without being subjected to discrimination or reprisal

•Voice grievance regarding treatment or care that is or fails to be furnished

•Be fully informed about a treatment or procedure and the expected outcome before it is performed

•Confidentiality of personal medical information

Privacy and Safety:

The patient has the right to:

•Personal privacy

•Receive care in a safe setting

•Be free from all forms of abuse or harassment

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

Advance Directives:

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Pennsylvania Statutes 20 Pa. CSA chapter 54. Advance Directives are documents which indicate your health care wishes in the event that you are not capable of making your own decisions. Advance directives are not used for decision making if the patient is able to make the decision. Pennsylvania recognizes two types of advance directives: durable power of attorney; and living wills.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

The Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.
If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Amanda Morello, BSN, RN
(Administrator West)
325 Central Ave, Lower Level
Malvern, PA 19355
610-644-7274

Sue Dougherty, RN
(Administrator East)
2 Bala Plaza, Suite IL 30
333 E City Ave
Bala Cynwyd, PA 19004
610-660-8470

Regina Nigro
(Administrator South)
H.C.C.II, Suite 2408
1088 W Baltimore Pike
Media, PA 19063
610-229-9373

Pennsylvania Dept. of Health
Department of Health hotline:
1-877-724 -3258 or
Room 532 Health & Welfare Building
625 Forster Streets,
Harrisburg, PA 17120
Phone:1-717-783-8980
State Web site: http://www.health.pa.gov

For complaints regarding a Physician, contact:
Department of State
Professional Compliance Office
P.O. Box 69522
2601 North Third Street
Harrisburg, PA 17106-9522
Phone 1-800-8222113
http://www.dos.pa.gov/ProfessionalLicensing/FileaComplaint

Medicare Ombudsman website:
https://www.medicare.gov/basics/your-medicare-rights/get-help-with-your-rights-protections

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General:
http://oig.hhs.gov

Accreditation Association for Ambulatory Health Care (AAAHC)
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847)853-6060 or email: info@aaahc.org

Physician Financial Interest and Ownership:

The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

List Physician Owners:

Nicole Albert, MD
Stuart Barish, MD
Maura Barr, DO
Norman M. Callahan, DO
Scott Fink, MD
Robert Frankel, MD
Joseph Herdman, MD
William Huntington, DO
Adam Kaufman, MD
Rupal Kothari, DO
Giancarlo Mercogliano, MD
Anil Sharma, MD
Michael Wolfson, MD
Patricia Wong, MD
Marc Zitin, MD

NOTICE OF PRIVACY PRACTICES

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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so, is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Amanda Morello BSN, RN
Administrator
Main Line Endoscopy Center, West
610.644.7274

Sue Dougherty, RN
Administrator
Main Line Endoscopy Center, East
610.660.8470

Regina Nigro
Administrator
Main Line Endoscopy Center, South
610.229.9373

----------Please Sign Below ----------

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

_____Date: _____

Effective: 02.15.2022

Main Line Endoscopy
Multiple Authorization Form

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, anesthesia and/or pathology providers are not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I am aware that I may receive a separate bill should there be any pathology performed from the pathology companies.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Main Line Endoscopy Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my procedure that the physicians who perform procedures/services at Main Line Endoscopy Center may have an ownership interest in Main Line Endoscopy Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Main Line Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my demographic and insurance information on this date and verify that all information reported to the center is correct.

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize Main Line Endoscopy Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature | Date Signed | Printed Name

Responsible Party Signature | Date Signed | Printed Name

Contact Information:
Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from Main Line Endoscopy Center, you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party | Print Name

_____ _____
Relationship to Patient | Date Signed

Main Line Endoscopy
Patient Medication Reconciliation Form

Allergies: ☐ Yes ☐ No known allergies		Latex Allergy ☐ Yes ☐ No	
Allergy (Drug)	**Reaction**	**Allergy (drug)**	**Reaction**

Current Prescriptive Medications — **Office Use Only**

Name of Medication (print please) ☐ NONE	Dose	How Often	Last Dose Taken/Time	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs — **Office Use Only**

Name of Medication (print please) ☐ NONE	Dose	How Often	Last Dose Taken/Time	Continue After Discharge	Stop After Discharge

Signature of patient: _____

Do Not Fill Out Form Below This Line

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often

Patient Signature/ Responsible Person: _____

Nurse Signature: _____

PATIENT STICKER