COVID-19 SCREENING PROCESS

- *If Patient says **NO** to all questions, proceed with surgery.*
- *If Patient says **YES** to **ANY** question, further follow-up is required through conditional questions and/or consent from provider*
- *If rescheduling is required, advise patient that the rescheduled procedure date must be at least TEN (10) days from today's date*

Screening Temperature ______________

1. Regardless of vaccination status do you have any of the following symptoms? *(symptoms may appear 2-14 days after exposure to the virus)*

• Fever or chills	☐ No	☐ Yes
• Cough	☐ No	☐ Yes
• Shortness of breath or difficulty breathing	☐ No	☐ Yes
• Fatigue	☐ No	☐ Yes
• Muscle or body aches	☐ No	☐ Yes
• Headache	☐ No	☐ Yes
• New loss of taste or smell	☐ No	☐ Yes
• Sore throat	☐ No	☐ Yes
• Congestion or runny nose	☐ No	☐ Yes
• Nausea or vomiting	☐ No	☐ Yes
• Diarrhea	☐ No	☐ Yes

If **YES**, when did the symptoms begin?______________________________

2. In the past 10 days, have you been in close physical contact with anyone who is known to have COVID-19?
3. In the last 10 days, have you tested positive for COVID-19? ☐ No ☐ Yes
4. Do you have a pending COVID-19 test result from a recent test? ☐ No ☐ Yes

Completed by:______________________________

Date:______________________________

AMSURG

Patient Label

REFERRING /PRIMARY PHYSICIAN

WHO IS YOUR PRIMARY PHYSICIAN?______________________________

ARE THERE ANY OTHER PHYSICIANS YOU WOULD LIKE TO GET A COPY OF TODAY'S REPORT? IF YES PLEASE LIST BELOW:

____

____

____

CONTACT/TRANSPORT INFORMATION

Who is driving you home today?______________________________

Relationship____

****Due to COVID-19, rides are NOT permitted into the center***
Your ride will be called once you arrive into Post-OP. They will be notified when to come back.

Phone number if they will not be waiting

Home#____________________________

Cell#_____________________________

Work#____________________________

For office use only

☐ Spoke with driver___________________________ Left Message______

☐ Spoke with MD

Waiting: Rm 1 Rm2 chairs

FORM-MULTIPLE AUTHORIZATION

AmSurg Center Non-System Policies

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's 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 and or physician's office is 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 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.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Hanover 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 surgery/procedure that the physicians who perform procedures/services at Hanover Endoscopy Center may have an ownership interest in Hanover Endoscopy 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 Hanover Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

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

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 Hanover Endoscopy Center policies pertaining to ADVANCED DIRECTIVES prior to the date of the procedure. Information regarding Advanced Directives along with official State Documents has been offered to me upon request.

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

______________________________ ______________________________

Signature of Patient or Responsible Party | Print Name

______________________________ ______________________________

Relationship to Patient | Date Signed

HANOVER ENDOSCOPY CENTER

Network Disclosure Form

I_______________________________________ have been informed that this facility is

- ☐ **In-Network** with my insurance plan
- ☐ **Out-of-Network** with my insurance plan and further, if I am out-of-network the following applies:
    - My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan;
    - I may be responsible for any excess amount above the allowed amount the health insurance pays or reimburses the provider for healthcare services I received; and

I acknowledge that I am knowingly accepting responsibility for any financial responsibility associated with healthcare services that I receive.

______________________________	______________________________
Signature of Patient/Legal Guardian	**Patient Name (Please Print)**
______________________________	______________________________
Witness Signature	**Date**

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:
Jenelle Purpura
973-410-1800
Center Leader

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: ______

HANOVER ENDOSCOPY CENTER
91 S JEFFERSON ROAD SUITE 300
WHIPPANY, NJ 07981

PLEASE FILL OUT THIS FORM AND BRING TO YOUR APPOINTMENT.
DO NOT MAIL TO OFFICE

PATIENT INFORMATION

PATIENT:______________________AGE:__________DATE OF BIRTH:________
ADDRESS:____
CITY:______________________STATE:________ZIP__________
HOME PHONE:______________________MOB ILE PHONE:__________
MARITAL STATUS:__________GENDER__________________
EMAIL ADDRESS______________________________________
HOW DO YOU PREFER TO BE CONTACTED: HOME PHONE:___MOBILE PHONE___EMAIL___
DO YOU RESIDE IN A SKILLED NURSING FACILITY?:__________________
FAMILY /REFERRING PHYSICIAN:______________________________
DO YOU HAVE A LIVING WILL?:__WOULD YOU LIKE INFORMATION ON LIVING WILLS___

PRIMARY INSURANCE INFORMATION

COMPANY:______________________TELEPHONE__________________
ADDRESS:______________________CITY/STATE/ZIP:______________
MEMBER #______________________GROUP#______________________
NAME OF INSURED:______________INSURED SSN:__________________
INSURED DATE OF BIRTH:__________RELATIONSHIP TO PATIENT:__________

SECONDARY INSURANCE INFORMATION

COMPANY:______________________TELEPHONE:__________________
ADDRESS:______________________CITY/STATE/ZIP:______________
MEMBER#______________________GROUP #______________________
NAME OF INSURED:______________INSURED SSN:__________________
INSURED DATE OF BIRTH:__________RELATIONSHIP TO PATIENT:__________

EMPLOYMENT INFORMATION

EMPLOYER______________________TELEPHONE__________________
ADDRESS:______________________CITY/STATE/ZIP______________
RELATION TO PATIENT:__________DATE OF INJURY:______________

EMERGENCY NOTIFICATION

CONTACT:______________________TELEPHONE:__________________
RELATIONSHIP:____

______________________________ ______________________________
SIGNATURE (PATIENT OR REPRESENTATIVE) DATE

FLORHAM PARK/HANOVER ENDOSCOPY CENTERS

WHAT CAN YOU EXPECT ON THE DAY OF YOUR PROCEDURE

CHECK IN

- You will receive a text reminder regarding your appointment date and time with pre procedure instructions.
- You will have forms to fill out upon your arrival at the Endoscopy Center.
- Please have your insurance card and ID available.
- After completing your paperwork you may have to wait for a short time before you are escorted into the preoperative area.

PREOPERATIVE AREA

- In the preoperative area a nurse will confirm your procedure and physician.
- We will have you change into a gown and help you get comfortable on the stretcher
- The nurse will go through a series of questions including your medical history and medications.
- The nurse will start an intravenous line that will be used to administer your sedation during your procedure
- You will speak with your anesthesiologist who will explain the process of the sedation for your procedure.

PROCEDURE ROOM

- In the procedure room you will be attached to monitors. Your heart rate/rhythm, oxygenation and blood pressure will be monitored throughout the procedure
- Oxygen will be supplied via a small plastic cannula which is placed just inside your nose and will remain until you are awake in the Recovery Room.
- Your physician will be available for any questions.
- The procedure will take between 15 min and an hour depending on the procedure(s) you are having. You should not feel any discomfort during the procedure.

RECOVERY ROOM

- You will spend approximately half an hour in the recovery room where they will continue to monitor your vital signs.
- You will be offered a drink and after which your intravenous line will be removed. You will be required to get dressed in bed without standing.
- Before you are discharged your physician will speak with you about your results. Any tissue samples will be sent for evaluation at a pathology lab.
- You will be given written discharge instructions and the nurse will go over those with you before you leave.
- A phone number for your physician will be included on the discharge instructions so that you can reach him/her if need be.
- You may feel groggy after the procedure due to the sedation. For this reason it is required that you have a family member or friend pick you up after the procedure.

POST DISCHARGE

- You will be called or sent a text within 72 hours of your procedure by a member of our staff as a follow up to your procedure.