EXPLANATION OF YOUR BILL

You are scheduled for a procedure at Glendale Endoscopy Center. The total cost may be comprised of four different fees: Glendale Endoscopy Center, Arizona Digestive Health, Westside Anesthesia, and Arizona Digestive Health Pathologist.

Glendale Endoscopy Center's fee: Co-pays, Co-Insurance, and Deductibles are due at the time of service; a **verification specialist will attempt to contact you to relay any amounts due on the day of service.** If your insurance company finds you are responsible for an additional balance after processing the claim, you will be billed separately for that amount and payment will be due within 30 days. If you have any **questions** regarding your bill from Glendale Endoscopy Center, please call the **Billing Department** at **(602) 424-4041**.

Arizona Digestive Health fee: This is your physician's fee. If you have any **questions** regarding your physician's bill, please call the **Billing Department** at **(602) 843-1265**, **prompt 2.**

Westside Anesthesia Services Plc

Westside Anesthesia fee: The sedation fee. If you have any **questions** regarding your bill for anesthesia services, please call the **Billing Department** at (**602) 654-2401**.

Arizona Digestive Health Pathology - (602) 844-5900

The **Pathology fee** is for any **biopsies** taken during your procedure. We cannot predict if or how many biopsies you may have **before** your procedure. You will be billed by **Arizona Digestive Health Pathology**. Please call them with billing **questions.**

Interpreting your insurance explanation of benefits (EOB):

- **Total Charges:** This is the total amount each provider will bill to insurance.
- **Allowed Amount:** This is the total amount expected to be paid by insurance and/or patient combined. (It is also called the negotiated amount or contracted amount).
- **Payable amount:** This is the amount that the primary insurance will pay.
- **Patient responsibility:** This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the "patient responsibility," depending on your contract.

I have read and understand the above information.

_____ _____

Patient Signature Date

_____

Print Name

GLENDALE ENDOSCOPY CENTER

General Instructions

You have been scheduled for a procedure at Glendale Endoscopy Center. Enclosed is your paperwork. Please complete and bring back, on the day of your appointment. Listed below are some instructions about your paperwork.

PLEASE READ AND SIGN ALL PAPERWORK

Please bring completed paperwork with you, and plan to stay **1 ½ - 2 hours**. Sometimes patient flow may make your stay longer.

Please bring your **insurance cards**, a **picture ID**, **co-pay/deductible**, and a list of your medications including dosage and how often the medications are taken.

Please make sure you have someone who can take you home.
Due to restrictions in the waiting area, your ride will be called to pick you up at discharge. You will be ready to go home in approximately 30 minutes after your procedure has finished.

We are **not** responsible for your lost or stolen articles. Please leave them at home or with your driver.

As a Medicare certified facility we have the duty to inform you of certain information prior to the date of your procedure. This information is contained in a document entitled *Patient Rights and Notification* which can be found in this packet, or on our website, www.tbirdendo.com. Please click on the heading "For Your Visit" and the link "Patient Forms."

If you do not have Internet access we will provide you with a paper copy of this information.

We look forward to seeing you.
If you have any questions, please call (602) 439-1717.
Thank you.

GLENDALE ENDOSCOPY CENTER

If you Need to Reschedule Your Procedure

When your procedure is scheduled at the Endoscopy Center, we reserve that time especially for you. It can often take weeks to get a procedure scheduled, due to the limited availability of time in the center. If you need to reschedule your procedure, please do so.

PROCEDURES MUST BE CANCELED OR RESCHEDULED AT LEAST 72 BUSINESS HOURS AHEAD OF TIME.

This will allow other patients to use this time in the Endoscopy Center. Patients who do not give advance notice of cancelled procedures may not be rescheduled.

To cancel or reschedule a procedure,
please call (602) 843-1265.

***If your insurance changes prior to your procedure, please call the Endoscopy Center and the Physician's Office to make sure your procedure will still be covered.**

Thank you!! ☺

GLENDALE ENDOSCOPY CENTER

PROPOFOL PATIENT EDUCATION

Propofol is one of the most commonly used medications for inducing anesthesia (making patients sleepy) for procedures. It is safely administered thousands of times a day nationwide and produces a level of deep sedation for your procedure.

Deep Sedation: Propofol induced deep sedation is a deeper level of sedation in which you do not respond purposefully to repeated or painful stimuli. Potential complications of any sedation include: breathing problems (decreased respiration, aspiration leading to pneumonia, airway blockage), heart problems (low blood pressure or irregular rhythm), for which you will be monitored and treated if necessary.

Potential Propofol side effects that you should report right away to your physician include:

- Allergic reactions during anesthesia/sedation are uncommon and occur in about 1 out of every 10,000---20,000 cases. Signs or symptoms of an allergic reaction may include: itching or hives, swelling in your face or hands, swelling or tingling in your mouth, or throat, chest tightness, or trouble breathing

Other rare potential side effects may include:

- Decrease in how much you urinate
- Dizziness, lightheadedness, or fainting
- Fever, chills, cough, sore throat, body aches
- Lower back or side pain
- Pain or fullness in your upper stomach
- Seizures
- Slow, fast or uneven heartbeat.

Your CRNA (Certified Registered Nurse Anesthetist) can answer any of your questions regarding your planned sedation and anesthesia care.

GLENDALE ENDOSCOPY CENTER

PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	MIDDLE NAME	SEX MALE FEMALE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	HOME PHONE

ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	MOBILE PHONE

HOW DO YOU PREFER TO BE CONTACTED: HOME PHONE_____ MOBILE PHONE_____ EMAIL_____

OCCUPATION	EMPLOYED BY	BUSINESS PHONE

NAME OF SPOUSE	EMPLOYED BY	BUSINESS PHONE

IN CASE OF EMERGENCY: Notify	RELATIONSHIP TO PATIENT	PHONE

PRIMARY or REFERRING PHYSICIAN

PRIMARY INSURANCE

NAME OF INSURANCE_____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

SUBSCRIBER _____

RELATION TO PATIENT _____

SOCIAL SECURITY# _____DOB _____

POLICY # _____

GROUP # _____

EFFECTIVE DATE _____

SECONDARY INSURANCE

NAME OF INSURANCE_____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

SUBSCRIBER _____

RELATION TO PATIENT _____

SOCIAL SECURITY# _____DOB _____

POLICY # _____

GROUP # _____

EFFECTIVE DATE _____

CONSENT FOR RELEASE OF TREATMENT RECORDS/ INSURANCE AUTHORIZATION

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of Glendale Endoscopy Center. Transmittal by Fax is authorized. I hereby assign benefits to Glendale Endoscopy Center. I understand that payment is due as services are provided unless I have authorized insurance billing and I have been informed of the cost of the procedure I am having today. If, after 60 days, an insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our understanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account I/we agree to pay attorney's fees and court incurred for collection.

PATIENT'S SIGNATURE _____ DATE _____

MRN _____

GLENDALE ENDOSCOPY CENTER

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize **Glendale Endoscopy Center** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Glendale Endoscopy Center** can refuse to treat me.

I have been informed that **Glendale Endoscopy Center** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Glendale Endoscopy Center**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Glendale Endoscopy Center** took before receiving my revocation.

I understand that **Glendale Endoscopy Center** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Glendale Endoscopy Center** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Glendale Endoscopy Center** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Glendale Endoscopy Center** must adhere to such restrictions.

With whom may we share your medical / financial information:

_____

_____

_____ _____

Signature of patient or patient's representative (Form MUST be completed before signing.) Date

_____

Printed name of patient or patient's representative

_____

Relationship to the patient

GLENDALE ENDOSCOPY CENTER

FINANCIAL AGREEMENT

If 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 Glendale 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 about 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 Glendale Endoscopy Center may have an ownership interest in Glendale 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 Glendale 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 Glendale 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 _____

Parent/Guardian Signature (if patient is a minor) _____ Date Signed _____ Printed Name _____

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

To revoke your consent to receive text messages or electronic mail from Glendale 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.
Do you have an Advanced Directive for healthcare? Yes or No (circle) If No, would you like any information? Yes or No (circle)
Did the patient bring a copy to the Center? Yes or No (circle) If provided, a copy is placed in patient's medical record.

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

Westside Anesthesia Services Plc

For Anesthesia Services Offered at Glendale Endoscopy Center

Glendale Endoscopy Center offers state of the art advanced anesthesia services to its patients. Propofol is an IV drug administered by a Certified Registered Nurse Anesthetist (CRNA), or Medical Doctor (MD) who is highly trained and specialized to safely administer your sedation. Propofol has distinct advantages over other medications in that it generally produces a much deeper level of sedation, ensuring that you will be asleep and comfortable during the procedure, yet allowing you to wake up and recover much faster after the procedure is completed.

The CRNA or MD will carefully deliver medications while monitoring your vital signs (pulse, blood pressure, respiratory rate, EKG rhythm strip, and pulse oximetry) during your procedure. Based upon your medical history and condition, your physician, nurse practitioner, or physician assistant will recommend that you have either Propofol administered by a CRNA or MD, or alternative forms of IV conscious sedation.

Please note that charge for anesthesia services (CRNA or MD) are separate from and in addition to charges for endoscopic services rendered by your physician, the surgery center, and pathology charges (biopsies, if taken). These charges are generally covered by your health insurance policy. In the event that your insurance will not cover anesthesia (CRNA or MD) administered Propofol IV sedation for your endoscopic procedure, alternative self-payment arrangements for this important services can be made with the billing department at 602-343-7954.

Non Coverage of anesthesia for services provided

_____(Initial Here) I agree to receive anesthesia services, as recommended by my physician / nurse practitioner / physician assistant, CRNA or MD administered IV Propofol, and I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance.

_____ _____

Patient Signature Date

_____

Print Name

GLENDALE ENDOSCOPY CENTER

Patient's Rights and Notification of Physician Ownership

PATIENT RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care free from coercion, manipulation, sexual abuse and sexual assault.
- To be provided privacy and security during the delivery of patient care service.
- 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.

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 PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE

- 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.
- 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.
- 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.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- 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.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- 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.
- 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.
- To know which facility rules and policies apply to his/her conduct while a patient.
- 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 patients' rights.
- 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.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- To be informed of your right to change providers if other qualified providers are available.

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 healthcare personnel 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.

Glendale Endoscopy Center
5823 W. Eugie Ave., Suite B, Glendale, AZ 85304
602-439-1717

Statement of Nondiscrimination:

Glendale 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.

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

Glendale 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 a 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

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 Arizona Statute Title 36-3201 through 36-3210. Arizona statute defines a health care directive as a document drafted in compliance with statute "to deal with a person's future health care decisions". All adults have the fundamental right to control their own medical care. Arizona law recognizes three distinct types of documents which can be executed in advance to provide a mechanism for healthcare decision making when a patient is no longer able to make the decisions directly. These documents are the Health Care Powers of Attorney, Living Wills, and Pre-hospital Medical Care Directives.

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.

Glendale 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 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 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 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:

Center Director

Glendale Endoscopy Center
Center Administrator
602-439-1717
5823 W. Eugie Ave, Suite B, Glendale, AZ 85304

State Agency

Arizona Department of Health Services
Attn: Bureau Chief
150 N. 18th Ave, Suite 450, Phoenix, AZ 85007
Phone: 602.364.3031 Fax: 602.364.4764
www.azdhs.gov

Medicare Ombudsman

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.
Medicare Ombudsman Web site:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
Medicare:
www.medicare.gov or call 1-800-633-4227
Office of the Inspector General: http://oig.hhs.gov

TJC

This facility is accredited by The Joint Commission (TJC).
Complaints or grievances may also be filed through:
Office of Quality and Patient Safety
Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Phone: 1-800-994-6610
or email: https://www.jointcommission.org/en-us

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.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Keng-Yu Chuang, MD; Mahesh Mokhashi, MD; Eugene Verkhovsky, MD.