Registration Form

Patient Information

Name: _____ Birth Gender: ☐Male ☐Female Gender Identity: ☐Male ☐Female
Last First Middle Initial Nickname

Address: _____
Street City State Zip Code

Social Security Number: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ _____ Occupation: _____
Company Name Phone Number

Ethnicity: ☐Non Hispanic or Latino ☐Hispanic or Latino ☐Declined

Race: ☐White ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Declined ☐American Indian/Alaska Native ☐Other

Preferred Language: ☐English ☐Spanish Other: _____

Marital Status: _____ Spouse's Name: _____ Spouse's DOB: _____

Spouse's Social Security Number _____ Spouse's Phone: _____

Spouse's Employer: _____ _____ Spouse's Occupation: _____
Company Name Phone Number

In Case of Emergency Contact: _____ _____
Name **Relation** **Phone Number**

Responsible Party (If Patient is Under 18)

Name: _____
Last First Middle Initial Nickname

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ _____ Occupation: _____ _____
Company Name Phone Number

Physician Information

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Medical Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

_____ _____ _____
Signature Date of Birth Date

_____ _____ _____
Legal Guardian Signature (If other than Patient) Legal Guardian (Print Name) Date

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Notice of Privacy Practices

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.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
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. 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, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law 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: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to 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 or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report 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-elated injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any 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.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.
Confidential Communications: 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. *Inspect and Obtain Copies:* In most cases, you have the right to look at or get a copy of your health information in electronic or paper form. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

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.

Changes in Privacy Practices We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person (s) listed below.

Mellissa McCarthy - Administrator
314-400-9999

Release of Medical Information
I authorize Advanced Endoscopy Center use/or disclose certain medical and/or billing information to:

Name: _____

Relationship: _____

Restrictions on the Disclosure of Medical Information (ONLY choose one below)

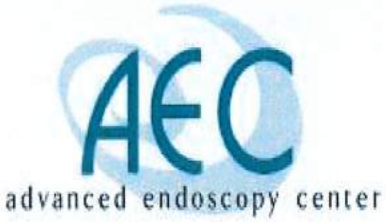
___ You can leave a detailed message (including billing, test results, medical information)

___ You leave a message with no detailed. Information except a call back number and "Advanced Endoscopy Center" identified.

___ You may not leave a message.

Signature: _____ Date: _____
Patient or Legal Guardian

Printed Name: _____ DOB: _____



Assignment of Benefits

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. If I default in payment I understand that I will be responsible for collection fees of 23% and/or legal fees.

Screening vs. Diagnostic Coverage

Insurance companies often provide screening benefits for routine screening colonoscopy. However, if during your screening procedure the physician removes a polyp or performs a biopsy, the procedure may be considered diagnostic and may not be covered as a screening exam. In this case, some insurance companies drop financial responsibility to the patient for all or part of the procedure cost. It is important for you to know if this applies to your routine screening benefits.

Insurance Information

A. **Medicare**: The physicians accept Medicare assignments. Medicare claims will be filed by us, and Medicare will pay us directly. You will be responsible for the twenty percent (20%) co-payment in most cases, annual deductible, and possible non-covered charges.
B. **Blue Cross Blue Shield/Anthem** and Other **Commercial Insurance**: Claims will be filed by us for your convenience. Most insurance Companies will send payment directly to us. In the event our payment is mailed to you, you are responsible for forwarding it to us for payment and any balance due on your account. You will also be responsible for any copayments, annual deductible amounts, and charges for non-covered services.
C. **Medicaid**. Your Medicaid card must be presented at the time of service. We are not accepting new patients at this time except for direct Physician referrals.
D. **HMO/PPO**: All claims will be processed directly from our office. **If a referral/authorization from your primary care doctor is required, you are responsible for obtaining and providing it to us at or before the time of your visit or you will be responsible for all charges**. You are also responsible for all co-payments, deductible amounts and non-covered services at the time of your visit. Co-payments should be paid at the time of your office visit unless prior arrangements have been made with the billing office.

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of birth**

If you have any questions regarding your bill, please ask to speak with our Billing Department. We are more than willing to work a payment schedule with you if necessary on any outstanding charges. Please call our Billing Department at (314) 400-9999. THANK YOU FOR YOUR COOPERATION.

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Problems List

Name: _____ Birth Date: _____ Date: _____

Medical Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Surgeries and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Medical History (Personal/Family)

	Patient's History	Family (Parent, Sibling, Child)
Colon Polyps:		
Colon Cancer:		
Colitis/Crohn's Disease		
Irritable Bowel:		
Stomach Ulcer:		
Gallstones:		
Pancreas Disease:		
Diabetes		
Breast Cancer:		
Uterine Cancer:		

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Patient Medication Information

Patient Name:_____ **Patient DOB:**_____

Primary Pharmacy:_____ **Pharmacy Phone: (____)**_____

Medication Allergies:

Name	Reaction
(example: Sulfa)	(rash)

Medications: (Please Print all Medications, Supplements and Over the Counter Medications)

Name	Dose/mg	How Many Times a Day do You Take This Medication?	Why do you take this Medication?
(example: Aleve)	(200mg)	(as needed)	(headaches)
(example: Coumadin)	(5mg)	(once daily)	(blood thinner)

ADVANCED DIRECTIVE

POLICY:
The Center shall provide each adult individual the choice to formulate Advance Directives with respect to the patient's rights of self-determination.

OBJECTIVE:
To enable this Center to protect each adult patient's right to participate in health care decision making to the maximum extent of his or her ability.

PROCEDURE:

1. The Center shall provide the patient, or as appropriate, the patient's representative in advance of the date of the procedure, with information concerning the Center's policies regarding the rights to make health care decisions and to formulate Advance Directives, and the way such decisions and directives will be implemented in the Center.
2. This Center shall provide upon request, written information describing:
   a. An individual's rights under applicable statutes
   b. Official state advance directive forms
3. The Center shall document in the individual's medical record whether or not the individual has executed an Advance Directive. For purposes of this policy, an Advance Directive means a written instruction that related to the provision of health care when the individual is incapacitated, such as a Durable Power of Attorney for Health Care, a Declaration pursuant to the National Death Act, or a Living Will.
4. This Center shall comply with applicable statutes and court decisions regarding Advanced Directives.
5. This Center shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.
6. This Center shall provide education to staff on issues that concern Advance Directives.
   a. Educational information about Advance Directive and the Center's policy and procedure regarding Advance Directives will be provided to the medical and nursing staff.
7. For purposes of this policy, the following terms shall be interpreted in accordance with their respective definitions as set forth below:
   a. Medical Decision Making: authorization for treatment, the withholding of treatment, or the withdrawing of treatment (including life-sustaining treatment) obtained from the patient or, in the event of the patient's incapacity, from the patient's surrogate decision maker.
   b. Life-Sustaining Treatment: any medical intervention, including the administration of fluids and nutrition by artificial means, that sustains life for a particular patient.
   c. Advance Directive: a written instruction, such as a Living Will, Durable Power of Attorney for Health Care, or other documentary evidence recognized by the courts of this state, relating to the provision of medical care when the author is incapacitated.
   d. Surrogate Decision Maker: an individual other than the patient to whom health care providers appropriately look for medical decision making regarding the patient's care when the patient is incapacitated. This individual may be formally appointed (e.g., by the patient in a Durable Power of Attorney for Health Care, or by a court in a conservatorship of guardianship proceedings) or, in the absence of a formal appointment, may be informally authorized by virtue of a relationship with the patient (e.g., the patient's next of kin or, in the absence of next of kin, close friend).
   e. Incapacitated: a condition of the patient where the capacity to make informed decisions regarding care is temporarily lost (e.g., due to unconsciousness, being under the influence of mind-altering substances, or otherwise suffering from treatable mental disability), is permanently lost (e.g., irreversible coma, persistent vegetative state, or untreatable brain injury, rendering understanding by the patient impossible), or never existed (e.g., congenital retardation rendering understanding by the patient impossible or severe brain injury as a child).

PATIENT'S RIGHTS

The rights of patient(s) include, but are not limited to:

1) Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
2) Considerate and respectful care.
3) Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
4) Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
5) Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6) Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7) Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and Treatments are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual.
8) Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the center. 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.
9) Reasonable responses to any reasonable requests he/she may make for service.
10) Leave the center even against the advice of his/her physicians.
11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
12) Be advised if center/personal physician proposed to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
13) Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the center.
14) Examine and receive an explanation of his/her bill regardless of source of payment.
15) Know which center rules and policies apply to his/her conduct as a patient.
16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17) Designate visitors of his/her choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless; (A) No visitors are allowed; (B) The facility reasonably determines that the presence of a particular visitor is detrimental to the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility; (C) the patient has indicated to the health facility staff that the patient no longer wants this person to visit.
18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the center policy on visitation. At a minimum, the center shall include any person living in the household.
19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
20) Be advised of his/her right to change his/her provider if other qualified providers are available.
21) The right to be informed that Leonard Weinstock, MD, Erik Thyssen, MD, Aman Singh, MD, Nikhil Banerjee, MD and Benjamin Root, MD have an ownership interest in Advanced Endoscopy Center, LLC.

Complaints may be addressed to the Administrator or:

Missouri Department of Health & Senior Services
912 Wildwood
P.O. Box 570
Jefferson City, MO 65102
(573) 751-6083

Office of Medicare Beneficiary Ombudsman
www.medicare.gov/Ombudsman/activities.asp
1-800-MEDICARE

Accreditation Association for Ambulatory Health Care (AAAHC)
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847) 853-6060