Gastro One
Excellence in Digestive Health
powered by
OneGI

Statement of Limitation Regarding Advance Directive

In the state of Tennessee, all patients have the right to participate in their own healthcare decisions and to make Advanced Directives or to execute Powers of Attorney or have Practitioner Orders for Life Sustaining treatment that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Gastro One respects and upholds those rights. However, unlike in an acute care hospital setting, Gastro One does not routinely perform "high risk" procedures. While no surgery is without risk, most surgeries performed at this center are considered to be at minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions regarding its risks, your expected recovery, and care after your surgery. Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. Tennessee law and CMS (CRF 416.50 Conditions for Coverage) permits us to decline to implement certain elements of your Advanced Directive, based on our conscience and commitment to patient care.:

It is the policy of Gastro One that if an adverse event occurs during your procedure or treatment, the medical surgical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. We will share your Advanced Directive and/or POST with the caregivers at the acute care hospital where you are transferred. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

If you do not agree with our facility policy we will assist you to reschedule your procedure in a facility more suited to meet your healthcare needs.

I have an Advanced Directive and/or POST. (It was provided/not provided to this facility.)	Yes No
I do not have an Advanced Directive or POST	Yes No
I would like information regarding creating an Advanced Directive or POST	Yes No
I agree to proceed with my scheduled procedure and authorize the suspension of my Do Not Resuscitate while at the surgery center	Yes No

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____ ←(Driver Sign)

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Gastro One, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, **Gastro One**, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact, you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update **Gastro One** when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (**If no, please provide an alternate mailing address below.**)

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

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Physician Owned Surgical Center

Gastro One- GI Diagnostic and Therapeutic Center, LLC, is partly owned by physicians and meets the federal definition of a "physician-owned hospital" in 42 C.F.R.489.3. Gastro One- GI Diagnostic and Therapeutic Center, LLC maintains a list of all its physician owners and this list is available to you upon request.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care order by your physician at a different facility other than Gastro One- GI Diagnostic and Therapeutic Center, LLC. You will not be treated differently by Gastro One- GI Diagnostic and Therapeutic Center, LLC if you choose to use a different facility. If desire, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact your physician or the Administrator at Gastro One- GI Diagnostic and Therapeutic Center, LLC.

Ali Akbar, MD
Carles R Surles, Jr, MD, MPH
Richard S Aycock, MD, FACG
William Z Taylor, MD
Joseph G Baltz, MD
Bryan F Thompson, MD
Carter Towne, MD
Sufiyan H Chaudhry, MD, MBA, FASGE
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Randall C Frederick, MD
Joshua French, MD
Gary A Wruble, MD
Peter D Snell, DO

Edwin Glassell, MD
Christopher M Griffith, MD
Fredrick R Harris, Jr, MD
Terrence L Jackson, Jr, MD
Paul King, MD
Sri Narra, MD
Eric John Ormseth, MD
Rajesh Ramachandran, MD
Ziad H Younes, MD
Shoaib Azam MD

Patient Signiture:_____ Date: _____

Gastro One
Excellence in Digestive Health

☐ 8000 Wolf River Blvd., #200, Germantown, TN 38138
☐ 1310 Wolf Park Drive, Germantown, TN 38138
☐ 1324 Wolf Park Drive, Germantown, TN 38138
☐ 2999 Center Oak Way, Germantown, TN 38138
☐ 3350 N Germantown Road, Bartlett, TN 38133
☐ 7668 Airways Blvd., Building B, Southaven, MS 38671

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release or disclose of all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name:_____ Date of Birth:_____

☐ **I hereby authorize the release of my medical records TO GASTRO ONE from ALL MEDICAL SOURCES so that my physician has the information he/she needs to provide medical care.**

☐ I only authorize the release of my medical records from _____ **TO GASTRO ONE**

☐ I hereby authorize the release of my medical records at **GASTRO ONE** to the following:

_____

Purpose of the disclosure is for medical care unless otherwise specified here:

_____

The authorization will expire on: _____
Date or Event may not exceed one year

This authorization applies to:

☐ **All medical records**

☐ Health care information only relating to the following treatment(s), condition (s) or dates of treatment:

_____

☐ Limited records to be released (examples lab work reports, imaging reports), specify:

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box indicating the information you do not want released or specify: _____

_____

☐ Substance abuse ☐ Psychological or psychiatric treatment ☐ HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that 1 can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient

Medicare Secondary Payer Questionnaire

(Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung	____No____Yes
Research Grant	____No____Yes
Veteran Affairs	____No____Yes

2. Was the illness/injury due to a work related accident/condition?

_____ No _____ Yes

Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

_____ No _____ Yes

Date of accident: _____

What type of accident caused the illness/injury?
_____ Automobile
_____ Non-automobile

4. Are you entitled to Medicare based on:

_____ Age
_____ Disability
_____ End Stage Renal Disease

5. Are you currently employed?

_____ No _____ Yes

6. Is your spouse currently employed?

_____ No _____ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ No _____ Yes

8. Does the employer that sponsors your GHP employ 20 or more employees?

_____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____ Date:_____

Please Print Name:_____

Medicare Secondary Payer Questionnaire
Long Form

Were you transferred to our facility from another hospital where you are currently an inpatient?

_____**No** _____ **Yes**

If YES, STOP. You will not need to fill out the rest of the form.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   _____ Yes. Date benefits began: CCYY/MM/DD _____
   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
   _____ No.
2. Are the services to be paid by a government program such as a research grant?
   _____ Yes. **Government program will pay primary benefits for these services.**
   _____ No.
3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   _____ Yes. **DVA IS PRIMARY FOR THESE SERVICES.**
   _____ No.
4. Was the illness/injury due to a work related accident/condition?
   _____ Yes. Date of injury/illness: CCYY/MM/DD _____
   Name and address of Workers' Compensation (WC) plan:
   _____
   _____
   _____
   Patient's policy or identification number _____
   Name and address of your employer:
   _____
   _____
   _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

_____ No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work related accident?
   _____ Yes. Date of accident: CCYY/MM/DD _____
   _____ No. **GO TO PART III.**
2. What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-automobile
   Name and address of no-fault or liability insurer:
   _____
   _____
   _____
   Insurance claim number _____

Continued on next page

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ Other.

3. Was another party responsible for this accident?

_____ Yes.

Name and address of any liability insurer:

_____

_____

_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ No. **GO TO PART III.**

PART III

1. Are you entitled to Medicare based on:

_____ Age. **Go to Part IV.**

_____ Disability. **Go to Part V.**

_____ ESRD. **Go to Part VI.**

PART IV - Age

1. Are you currently employed?

_____ Yes.

Name and address of your employer:

_____

_____

_____

_____ No. Date of retirement: CCYY/MM/DD _____

_____ No, never employed.

2. Is your spouse currently employed?

_____ Yes.

Name and address of spouse's employer:

_____ No. Date of retirement: CCYY/MM/DD _____

_____ No, never employed.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ Yes.

_____ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

_____ Yes.

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Continued on next page

Name and address of GHP:

_____
_____
_____

Policy identification number _____
Group identification number _____
Membership number_____
Name of policy holder _____
Relationship to patient _____

_____ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

_____ Yes.
Name and address of your employer:

_____
_____
_____

_____ No. Date of retirement: CCYY/MM/DD _____
_____ No, never employed

2. If married, is your spouse currently employed?

_____ Yes.
Name and address of your spouse's employer:

_____
_____
_____

_____ No.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's, current employment?

_____ Yes.
_____ No.

4. Are you covered under the group health plan of a family member other than your spouse?

_____ Yes.
Name and Address of your family members employer:

_____
_____
_____

_____ No.

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1, 2, 3 AND 4 STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

5. Does the employer that sponsors your GHP, employ 100 or more employees?

_____ Yes.

Continued on next page

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

_____

_____

_____

Policy identification number _____Member ID#_____

Group identification number _____

Name of policy holder _____

Relationship to patient _____

_____ No.

STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

_____ Yes.

Name and address of GHP:

_____

_____

_____

Policy identification number _____

Group identification number _____

Name of policy holder _____

Relationship to patient _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

_____ Yes. Date of transplant: CCYY/MM/DD _____

_____ No.

3. Have you received maintenance dialysis treatments?

_____ Yes. Date dialysis began: CCYY/MM/DD

If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD _____

_____ No.

4. Are you within the 30 month coordination period?

_____ Yes.

_____ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

_____ Yes. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

_____ No.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

_____ Yes.

Continued on next page

STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

_____ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

_____ Yes. **GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

_____ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

Patient Signature_____

Print Patient name_____

Date_____

"FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE (SEE SECTION 142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS".

GI Diagnostic and Therapeutic Center, L.L.C.

About Our Facility

The endoscopic examination you are having will be performed at the G. I. Diagnostic and Therapeutic Center, L.L.C. Our Endoscopy Center is the equivalent of any hospital based outpatient facility and, for this reason, a facility fee for each procedure performed will be charged for the use of G.I. Diagnostic and Therapeutic Center, L.L.C., just as a hospital would charge for the use of its facilities. Some insurance carriers however, regard these tests as outpatient surgery. If your insurance carrier falls in this group. You may be required to pay a deductible for this service. Diagnostic colonoscopies are ordered for patients who have a history of prior colon polyps, colon cancer or other colon diseases. They may also be ordered for patients having signs and symptoms such as abdominal pain, weight loss, or bleeding. These diagnostic colonoscopies do not qualify as a screening colonoscopy and are generally subject to a patient's deductible and co-insurance. Please familiarize yourself with your healthcare coverage.

In addition to the facility charge, you will also receive a charge from Gastro One for professional services provided by your physician for the endoscopic examination(s). The endoscopy center is owned by the physicians of Gastro One.

All charges will be submitted separately to your insurance carrier for consideration for payment according to the terms of your insurance plan. You may receive the following two statements:

- **G.I. Diagnostic and Therapeutic Center** – for use of its facilities
- **Gastro One** – for professional services provided by your physician, Pathology if tissue is removed and submitted for examination, and Certified Registered Nurse Anesthetist (CRNA) services provided.

GI Diagnostic and Therapeutic Center, L.L.C. and the physicians of Gastro One provide charitable care to the community by referral from select charitable healthcare organizations.

Under the Federal Patient Self-Determination Act, we, as healthcare providers, are obligated to inform you that, as a competent adult or as the parent/legal guardian of a minor, you have the right to make advance decisions regarding your healthcare. If a life threatening emergency occurs at G.I. Diagnostic and Therapeutic Center, L.L.C. it is the policy of Gastro One and G.I. Diagnostic and Therapeutic Center, L.L.C. to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute health care facility.

My signature below indicates I have read and understand all of the above information and I have received a copy of the Patient's Rights and Responsibilities. My signature also indicates I understand that G.I. Diagnostic and Therapeutic Center, L.L.C. is owned by Gastro One. I elect to have my procedure at G.I. Diagnostic and Therapeutic Center, L.L.C.

_____

Patient's or Legal Representative's Signature Date