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: _____

Patient Name (Print): _____ DOB: _____

Witness Signature: _____ Date: _____
↑ Driver Sign Here

Patient's Communication Preferences Regarding PHI

Telephone Communication Preferences

Home Phone # _____
Work Phone # _____
Mobile Phone # _____
Other Phone # _____

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) Date

Mail Communication Preferences

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

_____

Alternate Mailing Address

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

Gastro One
Excellence in Digestive Health
powered by
OneGI

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 provided 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 desired, 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.

Sufiyan H Chaudhry, MD, MBA, FASGE
Scott Duncan, MD
Joshua French, MD
Joseph G Baltz, MD
Christopher M Griffith, MD
Ziad H Younes, MD
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Peter D Snell, DO
Shoaib Azam MD
Robert S Wooten, MD, FACP, FACG
Sri Narra, MD
Maryam Mubashir, MD
Gary A Wruble, MD
Eric John Ormseth, MD

Patient's Signature: _____

Patient's Name (Print): _____

Patient's DOB: _____ DATE: _____

Gastro One
Excellence in Digestive Health
powered by
OneGI

☐ 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 I 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 Payor (MSP) Questionnaire

Patient Name: _____ Date of birth: _____ Date: _____

1. Are you receiving **Black Lung (BL) benefits**? ___ No ___ Yes
2. Are any of your services to be paid by a **government research grant**? ___ No ___ Yes
3. Are any of your services to be paid for by the **Dept of Veteran Affairs**? ___ No ___ Yes
(Requires authorization from the VA to be seen at this clinic)
4. Are any of your services due to a work-related illness/injury for which a **Worker's Compensation** plan must be billed? ___ No ___ Yes
5. Are any of your services due to an **automobile accident**? ___ No ___ Yes

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6. **Are you entitled to Medicare based on your age (65 and over)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
    a. Are you currently **ACTIVELY** employed? ___ No ___ Yes
    (**If YES**, please answer the following questions)
        - Are you covered by your employer's group health plan? ___ No ___ Yes
        - Does your employer employ 20 or more people? ___ No ___ Yes

    b. Is your spouse currently employed? ___ No ___ Yes
    (**If YES**, please answer the following questions)
        - Are you covered by your spouse's employer's group health plan? ___ No ___ Yes
        - Does your spouse's employer employ 20 or more people? ___ No ___ Yes

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7. **Are you entitled to Medicare based on disability**? ___ No ___ Yes
(**If YES**, please answer the following questions)
    a. Are you currently employed? ___ No ___ Yes
    (**If YES**, please answer the following questions)
        - Are you covered by your employer's group health plan? ___ No ___ Yes
        - Does your employer employ 100 or more people? ___ No ___ Yes

    b. Is a family member (parent or spouse) currently employed? ___ No ___ Yes
    (**If YES**, please answer the following questions)
        - Are you covered by the family member's employer's group health plan? ___ No ___ Yes
            - Does your family member's employer employ 100 or more people? ___ No ___ Yes

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8. **Are you entitled to Medicare as a result of ESRD (End Stage Renal Disease)**? ___ No ___ Yes
(**If YES**, please answer the following questions)
    a. Do you have group health plan coverage? ___ No ___ Yes
    b. Are you within the 30 month "coordination" period? ___ No ___ Yes
    If YES to both a and b, please answer the following questions:
    - Are you entitled to Medicare based on ESRD and age (65+)? ___ No ___ Yes

    If YES, please answer the following question:
    - Was your initial entitlement to Medicare based on age (65+)? ___ No ___ Yes
      *** If YES, please make sure to complete section 6, above ***
    - Are you entitled to Medicare based on ESRD and disability? ___ No ___ Yes

    If YES, please answer the following questions:
    - Was your initial entitlement to Medicare based on disability? ___ No ___ Yes
      ***If YES, please make sure to complete section 7, above ***

Patient Signature:_____

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.

G.I. 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 Center, L.L.C. it is the policy of Gastro One and G.I. Diagnostic 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 Center, L.L.C.

Patient's or Legal Representative's Signature Date

Print Patient's Name DOB