Hillmont GI / Springfield ASC
Medical History

Name:_____ **DOB:**_____ **Age:**_____ **Today's Date:** _____

Occupation:_____ **Marital Status:**_____

Reason for Visit:_____

Height:_____feet _____inches **Weight:**_____pounds

Do you have a living will/advanced directive? ☐ Yes ☐ No Please provide a copy at your next visit

Family History (include relation if applicable):

☐ Colon Cancer:_____ ☐ Colon polyps:_____

☐ Ulcerative Colitis or Crohn's Disease: _____ ☐ Liver

Disease:_____

Medications/Dose/Frequency (include over-the-counter drugs):

_____

_____

_____

☐ Allergies to medications, latex or IV dye:_____

☐ Any previous reactions to anesthesia:_____

☐ **Blood Thinner Treatment:** ☐ Coumadin/Warfarin ☐ Plavix ☐ Aspirin

Do you smoke? ☐ Yes ☐ No # of packs per day:____ / # of years smoke:____ / Quit?:_____

Do you use alcohol? ☐ Yes ☐ No # of drinks per week:____

☐ History of excessive alcohol use:_____

☐ History of drug/substance abuse:_____

Prior Surgical History (list all operations):

_____

_____

☐ Heart Attack	☐ Angina	☐ Pacemaker	☐ Coronary Blockages
☐ Congestive Heart Failure	☐ Irregular Heart Rhythm	☐ Artificial Valve	☐ Heart Valve problems
☐ Stent or Angioplasty	☐ Bypass	☐ Defibrillator	☐ Bleeding Problems
☐ Diabetes	☐ High Blood Pressure	☐ Stroke/TIA	☐ Asthma
☐ COPD/Emphysema	☐ Sleep Apnea	☐ Home Oxygen	☐ Kidney disease
☐ Kidney dialysis	☐ Thyroid disease	☐ Lupus	☐ Sarcoid
☐ HIV	☐ Hepatitis B or C	☐ Pancreatitis	☐ Anemia
☐ Anxiety/Depression	☐ Bipolar disorder	☐ Rheumatoid arthritis	
☐ Prior blood transfusion	☐ History of Cancer:_____		

Which of the following are you experiencing? Please check either 'Yes' or 'No'

Constitutional

Recent weight change	☐ No ☐ Yes
Fever	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes

Eyes

Blurred vision	☐ No ☐ Yes
Glaucoma	☐ No ☐ Yes

Ears/Nose/Mouth/Throat

Hearing loss	☐ No ☐ Yes
Ringing in the ears	☐ No ☐ Yes
Mouth sores	☐ No ☐ Yes

Cardiovascular

Chest pain	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes
Swelling of the ankles	☐ No ☐ Yes

Respiratory

Chronic cough	☐ No ☐ Yes
Spitting up blood	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes

Genitourinary

Burning when urinating	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes

Musculoskeletal

Joint pain or swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle pain	☐ No ☐ Yes

Skin

Rash	☐ No ☐ Yes
Itching	☐ No ☐ Yes

Gastrointestinal

Poor appetite	☐ No ☐ Yes
Swallowing difficulty	☐ No ☐ Yes
Heartburn	☐ No ☐ Yes
Nausea/Vomiting	☐ No ☐ Yes
Bloating	☐ No ☐ Yes
Belching	☐ No ☐ Yes
Regurgitation	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Recent change in bowel habits	☐ No ☐ Yes
Rectal bleeding	☐ No ☐ Yes
Black, tarry stools	☐ No ☐ Yes
Blood in stools	☐ No ☐ Yes

Neurological

Headaches	☐ No ☐ Yes
Seizures	☐ No ☐ Yes
Strokes	☐ No ☐ Yes
Numbness	☐ No ☐ Yes

Psychiatric

Memory loss or confusion	☐ No ☐ Yes
Depression/Anxiety	☐ No ☐ Yes

Endocrine

Heat or cold intolerance	☐ No ☐ Yes
Excessive thirst	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Hematological

Bleeding/bruising tendency	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Blood transfusion	☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

How did you hear about us?_____

Patient's Signature:_____

Comments/Notes: **Reviewed:**

_____ Date:_____ By:_____

Hillmont GI / Springfield ASC

PATIENT REGISTRATION FORM

Please PRINT CLEARLY so we can read your information accurately. Thank you.

NAME:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL PHONE:**_____

GENDER: ○ Male / ○ Female **DATE OF BIRTH:**_____ **SOCIAL SECURITY #:**_____

EMPLOYER:_____ **EMPLOYER PHONE #:**_____

EMPLOYER ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

E-MAIL ADDRESS:_____ *(for you to access your health information electronically)*

PRIMARY PHYSICIAN:_____ **PHONE NUMBER:**_____

REFERRING PHYSICIAN:_____ **PHONE NUMBER:**_____

MARITAL STATUS: ○ Single ○ Married ○ Partnered ○ Widowed

EMERGENCY CONTACT #1:_____ **PHONE:**_____ **RELATIONSHIP:**_____

EMERGENCY CONTACT #2:_____ **PHONE:**_____ **RELATIONSHIP:**_____

PHARMACY:_____ **PHARMACY PHONE #:**_____

PHARMACY ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

FOR GOVERNMENT HEALTHCARE ANALYSIS USE

RACE (Only check one selection):

○ American Indian or Alaska Native ○ More than one race ○ White
○ Asian ○ Native Hawaiian ○ Do not wish to provide
○ Black or African-American ○ Other Pacific Islander

ETHNICITY (Only check one selection):

○ Hispanic or Latino ○ Not Hispanic or Latino ○ Do not wish to provide

PRIMARY / PREFERRED LANGUAGE (Only check/write one selection):

○ Chinese ○ English ○ Hindi ○ Italian
○ Korean ○ Spanish ○ Vietnamese ○ American Sign Language
○ Other:_____ ○ Do not wish to provide

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME:_____

○ **The insured policyholder is the patient**

(if under spouse, fill in spouse's name and date of birth)

Insured's Name:_____

Insured Date of Birth:_____

Insured's Social Security #:_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME:_____

○ **The insured policyholder is the patient**

(if under spouse, fill in spouse's name and date of birth)

Insured's Name:_____

Insured Date of Birth:_____

Insured's Social Security #:_____

U.S. digestive health

BE HEALTHY TO THE CORE

Site: Hillmont

Address: _____

_____

Consent to Treat/Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I understand and agree that Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations.

I authorize the release of any medical information necessary to process my claims to the insurance companies/carriers listed in my file . I authorize and assign payment of medical benefits on my behalf directly to Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health. A copy of this authorization will be as valid as the original.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

U.S. Digestive Health and Affiliates
Authorization for Release of Medical Record Information

Practice Location Name/Address: _____

Patient's Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

I hereby authorize the release of my health information as listed below:

Person or entity authorized to receive information: ____Hillmont GI_____

Address for Release:1811 Bethlehem Pike Flourtown PA 19031 Phone 215-402-0800 Fax 215-836-2429

Purpose of Release: _____

Dates of Service: ☐ All ☐ Dates of Services: _____

Description of Information: ☐ Medical Record ☐ Billing Record ☐ Complete Record

☐ Specific Information: _____

_____

_____

Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. See waiver below.

☐ Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. 1690.108)
☐ Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. 7111)
☐ Include AIDS/HIV related records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. 7607)
☐ Include limited AIDS/HIV-Related records as follows: _____
☐ Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 PA C.S. A 5945.1 and 23 PA C.S.A 6116, respectively)

Please provide the records in the following format if possible:
☐ Electronic ☐ Mobile device/disk ☐ Secure Email: _____
☐ Paper

1. This authorization will expire: ☐ Date: _____ ☐ Event: _____ ☐ 1 year
2. Unless otherwise specified, this authorization will expire one year after the date of the request
3. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or the entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to my revocation and will not apply to information that has already been released in response to this authorization.
4. This authorization is voluntary. I can refuse to sign this authorization.

U.S. Digestive Health and Affiliates
Authorization for Release of Medical Record Information

5. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations
6. I understand that this information may be re-released by the recipient and no longer protected
7. By signing below, I certify that I understand the nature of this Release
8. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization
9. If mental health records are being released as permitted by the Mental Health Procedures Act, I understand that I have ta right, subject to 55 PA Code 5100.33 to inspect the material to be released
10. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further discloser is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentially of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
11. By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above

This waiver is applicable only to this request and is not meant to be a general waiver.

_____ _____
Signature of patient or Patient's Representative/Guardian Date

_____
Relationship to Patient

Contact info: Please provide contact information in the event there is a question related to the request.

Phone: _____

Email: _____

U.S. digestive health
BE HEALTHY TO THE CORE

Site: Hillmont GI
Address: _____
_____

Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing Regional Gastroenterology Associates of Lancaster, d/b/a U.S. Digestive Health (USDH). USDH is committed to providing you with the best care possible, while minimizing your out-of-pocket expenses and making the payment of any private balances as easy as possible. In order to do this, our financial department will need your assistance and your understanding of our financial policy. Please read and sign this Financial Policy prior to your treatment.

We participate with most major insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but you do not provide up-to-date insurance information, you will be considered self-pay until insurance coverage can be confirmed. It is your responsibility to know your insurance benefits. Please contact your insurance company with any coverage questions.

All patients must complete our patient registration process before seeing the physician or provider. We will need a copy of your identification card and a current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Insurance:
For your convenience we will submit claims to your insurance carrier for payment provided we are contracted with your chosen insurance. We will submit to primary, secondary and supplemental plans as needed.

It is your responsibility to provide USDH with current, accurate billing information at the time of your visit and to notify us of any changes in the information. If the information provided is inaccurate or inactive, you will be considered self-pay for services.

Co-payments are due at the time services are provided. This is a contractual agreement you have with your health plan and our contractual obligation with participating insurance carriers. If payments are not made at time of service, there may be a Co-Pay Billing Fee. USDH accepts cash, checks, debit cards and major credit cards. Returned checks are subject to a reasonable processing fee.

Referrals:

It is your responsibility to determine if you require a referral before your appointment. If you arrive without a referral and one is needed, you may be asked to either pay for your appointment in full before being seen or to reschedule your appointment pending the referral.

Pre-Authorizations:
USDH will obtain precertification for any services that require pre-authorization. Pre-authorization does not guarantee that the service will be covered or paid by your insurance carrier. Precertification is the process of notifying the insurance carrier of certain treatment services you will receive so the insurance carrier can determine medical necessity.

Our relationship is with the patient, not the insurance carrier. While pre-authorizations, referrals and the filing of insurance claims is a courtesy extended to our patients, all charges are your responsibility. If you disagree with a bill from our office, please contact your insurance company as the first step to determine the reason for any balance or non-coverage of a service. It is the patient's responsibility to contact their insurance carrier prior to treatment and service to determine specific guidelines for coverage, deductibles and co-pays based on your individual coverage.

Self-Pay:
You are expected to pay a minimum deposit of $65.00 for all office visits which will be applied to your total charge for services that day. Self-Pay discounts are offered and applied to your balance. Remaining balances paid within 30 days of the date of service are eligible for an additional prompt payment discount. If at any time you are unable to pay a balance due, please contact our office for assistance or to establish a payment plan.

Balances:
You have a financial responsibility to pay for any services received at USDH. This includes co-pays, co-insurance, deductibles, non-covered services and self-pay fees. Please understand that that if payment or a payment plan is not established after issuance of three statements, the balance on the account may be placed with a collection agency. Reasonable costs associated with collection efforts will be your responsibility.

I understand that I am financially responsible for any co-pays, co-insurance, deductibles, non-covered services and self-pay fees. I have read and understand this Financial Policy and by signing I accept all terms and conditions described above.

No Show and Cancellation Policy:
Last minute cancellations and no-shows prevent other patients from receiving necessary treatment and creates an added expense for the Practice and physician. To promote efficient access to our services, we request that you notify us at least 24 hours in advance if you cannot keep your appointment. In the event that an appointment is missed or cancelled with less than 24- hour notice, a $25.00 charge will be billed to your account.

_____ _____
Signature of Patient or Authorized Representative Date

Relationship to Patient: _____

U.S. digestive health
BE HEALTHY TO THE CORE

Site: ____Hillmont_____

Address: _____

_____

HIPAA Contact Information

Patient Name: _____ Date of Birth: _____

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at my address on record ☐ Yes ☐ No

You may contact me by phone at my contact number on record ☐ Yes ☐ No

You may leave a message on my contact number on record ☐ Yes ☐ No

You may contact me/leave a message at the following number: _____

You may discuss my healthcare needs/release necessary medical information with family and/or others involved in my care as listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient

SPRINGFIELD AMBULATORY SURGERY CENTER

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

As a patient of the **Springfield Ambulatory Surgery Center,** you have the right to receive the following information in advance of the date of the procedure.

PATIENT'S BILL OF RIGHTS:

Every patient has the right to be treated as an individual with his/her rights respected. The facility and medical staff have adopted the following list of patient's rights.

Patient Rights:

•To receive respectful, considerate and dignified care given by competent personnel.

•To be provided, upon request, the name of his/her attending practitioner, the names of all other practitioners directly participating in his/her care, and the names and functions of other health care persons having direct contact with the patient.

•The right to have records pertaining to his/her medical care treated as confidential, except as otherwise provided by law.

•The opportunity to approve or refuse release of his/her medical care records prior to submission to any party, including third parties based on contractual arrangements, except as otherwise provided by law.

•Consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.

•To expect emergency procedures to be implemented without unnecessary delay.

•The right to know what ambulatory care facility rules and regulations apply to his/her conduct as a patient.

•To be given the opportunity to participate in decisions involving his/her health care, except when such participation is contraindicated for medical reasons.

•to good quality care and high professional standards that are continually maintained and reviewed.

•to full information in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.

•Except in cases of emergency, the practitioner shall obtain the necessary informed consent prior to the start of the procedure.

•A patient, or if unable to give informed consent, a person responsible to the patient, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person shall give informed consent prior to actual participation in the program. A patient or responsible person may refuse to continue in a program to which he or she has previously given informed consent.

•The right to refuse the participation of Center in the patient's treatment.

•Right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.

•to medical and nursing services without discrimination based upon age, race, color, religion, gender, national origin, handicap, disability or source of payment.

•A patient who does not speak English or is deaf shall have access, when necessary, to interpretation services.

•A patient who is blind or deaf shall have alternative communicative assistance available to them, if requested.

•Shall have access to the information contained in his/her medical records at the ambulatory care facility, unless the attending practitioner for medical reasons specifically restricts access.

•To expect good management techniques to be practiced within the ambulatory care facility. Techniques shall make effective use of the patient's time and shall avoid personal discomfort of the patient.

•To be transferred when an emergency occurs to another facility and requires transfer to a location capable of providing emergency services, with notification to both patient or their responsible party and the facility prior to the patient's transfer.

•To examine and receive a detailed explanation of his/her bill.

•To expect that the ASC will provide information for continuing health requirements following discharge and the means for meeting them.

•The right, without recrimination, to voice comments, suggestions, complaints and grievances regarding care; to have those complaints reviewed and when possible, resolved; and when not resolved, to obtain information regarding external appeals, as required by state and Federal law and regulations.

•To be informed verbally and in writing, in terms the patient could understand, of his/her rights, responsibilities, and expected conduct by the ambulatory care facility at the time of admission.

•The right to information covering services available at the ASC, the fees related to those services, and the payment policies governing restitution for services rendered.

•The right to information on the provision of after hours and emergency services for care and treatment rendered at the ASC.

•The right to information on advance directives, as required by state or Federal law and regulations**.** Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the Patient will be offered care at another facility that will comply with their wishes.

If you request, an official state Advance Directive Form will be provided to you

•The right to be provided, upon request, information pertaining to the process of credentialing of the practitioners rendering care and treatment at the ASC.

•The right not to be misled by the organization's marketing or advertising regarding their competence and capabilities.

•To obtain names, addresses, and telephone numbers from the Center Director of the governmental offices were complaints may be lodged.

•To obtain names, addresses and telephone numbers of offices where information concerning Medicare and Medicaid coverage can be obtained.

The following are the names and/or agencies you may contact:

Susan Potts RN (Center Director)
Springfield Ambulatory Surgery Center
1528 Bethlehem Pike
Flourtown, PA 19031
215-402-0600

You may contact your state representative to report a complaint:

Pennsylvania Department of Health website:
www.dsf.health.state.pa.us

Sites for address and phone numbers of regulatory agencies:
Complaint Hotline: 1-877-724-3258

Medicare Ombudsman website
www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

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.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

_____,
hereby acknowledge receipt of the Patient Rights & Notification of Ownership.

Signed:_____
Date:_____

U.S. digestive health
BE HEALTHY TO THE CORE

Site information/Label

Site: Hillmont

Address: _____

_____

Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have viewed and have been offered a copy of U.S. Digestive Health's "Notice of Privacy Practices" ("NPP"). This NPP describes in detail how we might use or disclose your protected health information.

I understand that this organization has the right to change its NPP from time to time and I my request a copy of the NPP at any time or review it on the company website.

I am aware that I may request a copy of the NPP at any time and that a current version of the NPP is available at www.USDigestiveHealth.com under "Privacy Policy".

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient

If Applicable

The patient refused or was unable to acknowledge the Notice of Privacy Practices (please indicate reason:

_____
_____
_____

_____ _____
Staff Representative Signature Date

U.S. Digestive Health and Affiliates - HIPAA Patient Privacy
Your Information. Your Rights. Our Responsibilities.

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.**

We are required to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information and to abide by the terms of this Notice as currently in effect. Protected health information, (PHI) includes information that we collect about your past, present or future health, health care we provide to you, and payment for your health care.

Who Follows This Notice:

This Joint Notice of Privacy Practices applies to entities that are managed by or affiliated with U.S. Digestive Health (USDH), including Regional Gastroenterology of Lancaster, Ltd. (RGAL); RGAL Anesthesia Services, LLC; Main Line Gastroenterology Associates; Digestive Disease Associates; Carlisle Digestive Disease Associates; Carlisle Endoscopy Center; USDH at Royersford; Pottstown Ambulatory Center; West Chester GI; Hillmont GI; The Center for GI Health (CGI); The Colonoscopy Center, Landsdale; the Colonoscopy Center, Sellersville; Brandywine Valley Endoscopy Center (BVE); and includes their practices, sites of service, staff, providers and workforce members.

Participation in Clinically Integrated Networks:

In order to improve the quality of care and access to health information, US Digestive Health participates in the following Clinically Integrated Networks (CIN) for secure exchange of information between providers who are part of the care team. The networks include:

- Main Line Health
- Lancaster General Health Community Care Collaborative
- Tower Health Partners Clinical Integration Program

Your Rights - You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition

- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will honor your request unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one

accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care unless you specifically restrict the individual from access
- Share information in a disaster relief situation
- Include your information in a directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again. If you prefer not to be contacted for fundraising purposes, you may "opt out" of being contacted by notifying the USDH Privacy Officer via email at Compliance@USDhealth.com or via telephone at 610-234-7900

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- We may contact you to provide appointment reminders or information about treatment alternatives and other health-related benefits and services that may be of interest to the individual. We do not need to obtain written permission from you to provide telephone, text or mail reminders of appointments. You have the right to opt out of text reminders.
- We do not need to obtain written permission to provide you with information regarding your course of treatment, case management coordination, to describe health-related products or services we provide or to contact you regarding treatment alternatives.
- Unless you restrict disclosure, we may disclose your discharge instructions and information related to your care to the individual driving you home or otherwise identified as assisting in your care.
- This notice is effective April 7, 2021
- You may contact the USDH Privacy Officer

  Terry Jackson, MBA, CHC, CHPC
  707 Eagleview Blvd, Suite 100
  Exton, PA 19341
  Email: Compliance@USDHealth.com
  Phone: 610-234-7900

Effective 10/1/2021

Non-Discrimination Notice

U.S. Digestive Health (USDH) and its affiliates comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. USDH does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender, sexual orientation or gender identity. We provide free aids and services to people with disabilities to communicate effectively including:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Practice Administrator for this location.

If you believe that USDH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

U.S. Digestive Health
Privacy Officer
707 Eagleview Blvd, Suite 100
Exton, PA 19341
Email: Compliance@usdhealth.com
Phone: 610-234-7922

You can file a grievance in person or by mail, email or telephone. If you need help filing a grievance, the Practice Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-xxx-xxx-xxxx（TTY：1-xxx-xxx-xxxx）。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-xxx-xxx-xxxx).

Pennsylvania Dutch - Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오.

Italian - ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Arabic-ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx (رقم Arab) xxx-xxx-xxxx(هاتف الصم والبكم: 1-xxx-xxx-xxxx

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-xxx-xxx-xxxx (ATS : 1-xxx-xxx-xxxx).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Gujarati - **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

French Creole - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Cambodian - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)។
Portuguese - ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).