# *US Digestive Health / 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:_____

*US Digestive Health / 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:** O Male / O 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:** O Single O Married O Partnered O 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):**

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

**ETHNICITY (Only check one selection):**

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

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

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

## PRIMARY INSURANCE INFORMATION

**INSURANCE CO. NAME:**_____

O **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:**_____

O **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 #:**_____

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**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

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# 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: _____

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## 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

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

Every patient has the right to be treated as an individual and to actively participate in and make informed decisions regarding his/her care. The facility and medical staff have adopted the following list of patient's rights and responsibilities, which are communicated to each patient, or patient's representative/surrogate in advance of the procedure.

**Patient Rights:**

Every patient of a facility shall have the right:

a) To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
b) To receive considerate, respectful and dignified care.
c) To be provided privacy and security during the delivery of patient care service.
d) To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
e) To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
f) When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
g) To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
h) To be free from mental and physical abuse, or exploitation during the course of patient care.
i) Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
j) Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
k) To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
l) Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
m) Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
n) To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
o)To be informed of the right to change providers if one is available
p) To know which facility rules and policies apply to his/her conduct while a patient.
q) To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
r) To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
s) To examine and receive an explanation of his/her bill regardless of source of payment.
t) To appropriate assessment and management of pain.
u) To be advised if the physician providing care has a financial interest in the surgery center.

**Patient Responsibilities:**

•To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
•To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
•To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
•To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
•To accept personal financial responsibility for any charges not covered by their insurance.
• To be respectful of all the healthcare professional and staff as well as other patients.

**If you need an Interpreter:**

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Springfield Ambulatory Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

Springfield Ambulatory Surgery Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Springfield Ambulatory Surgery Center遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

**Rights and Respect for Property and Person**

***The patient has the right to:***
•Exercise his or her rights without being subjected to discrimination or reprisal
•Voice grievance regarding treatment or care that is or fails to be furnished
•Be fully informed about a treatment or procedure and the expected outcome before it is performed
•Confidentiality of personal medical information

**Privacy and Safety** ***The patient has the right to:***
•Personal privacy

•Receive care in a safe setting

•Be free from all forms of abuse or harassment

**Advance Directives**

***An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Pennsylvania Statutes 20 Pa. CSA chapter 54. Advance Directives are documents which indicate your health care wishes in the event that you are not capable of making your own decisions. Advance directives are not used for decision making if the patient is able to make the decision. Pennsylvania recognizes two types of advance directives: durable power of attorney; and living wills.***

***You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.***

**Advance Directives cont.**

The Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.
If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

**Complaints/Grievances:** If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution, You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

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

**Elizabeth Eliff RN BSN**
**1528 Bethlehem Pike**
**Flourtown, PA 19031**
**215 402-0600**

Pennsylvania Dept. of Health
Department of Health hotline:
1-800-254-5164
or
7th & Forster Streets,
Harrisburg, PA 17120
1-877-PA-HEALTH
**State Web site: http://www.health.state.pa.us/**

**Medicare Ombudsman website**
www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

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

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

**Accreditation Association for Ambulatory Health Care (AAAHC)**
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847)853-6060 or email: info@aaahc.org

**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.*

**List Physician Owners**
Robert Boynton, Steven Nack, James Taterka, Victor Araya, Besma Samdani

**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.**

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

Signed: _____

Date: _____

**2.21.2022**

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF PROCEDURE

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**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

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

# Your Rights and Protections Against Surprise Medical Bills

**When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.**

## What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

## You are protected from balance billing for:

**Certain services at an in-network hospital or ambulatory surgical center**
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

Pennsylvania also provides partial balance billing protections to limit billing amounts to in-network cost sharing amounts for emergency services and most health care professionals.

## When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact either the location at which the services were provided or our toll-free billing customer service line at 1-877-543-9753. You may also contact our Compliance Department by email at Compliance@usdhealth.com or call the USDH corporate office at 610-234-7900 for assistance.

Visit No Surprises: Understand your rights against surprise medical bills | CMS for more information about your rights under federal law.

Visit Regular Session 2019-2020 Senate Bill 0822 P.N. 1128 (state.pa.us) for more information about your rights under [state laws].]