Capital Digestive Care, LLC

Ambulatory Endoscopy Center of Maryland
A Division of AmSurg Corporation

CapitalDigestiveCare.com/mdd

Dear Patient:

Thank you for inquiring about scheduling a colonoscopy with Capital Digestive Care. We have developed a protocol to schedule a colonoscopy for relatively healthy patients without an initial pre-procedure consultation. The first part of that protocol requires that you completely fill out the enclosed Personal Information, Insurance and General Authorization for Treatment form and the enclosed Comprehensive Medical History forms and return them to our office. After receiving all of the completed forms back at our office, we will review them and then contact you about scheduling your colonoscopy. After scheduling your colonoscopy, we will send you specific instructions on how to prepare and cleanse your colon prior to your procedure as well as other general instructions.

*****BE SURE TO REVIEW BOTH FRONT AND BACK OF PACKET*****

It is vitally important that you fill out the Comprehensive Medical History forms as completely as possible. We strive to make your procedural experience as pleasant and safe as possible. In order to give you the appropriate pre-procedural instructions we need to review your entire medical history.

Please pay special attention to filling out the dosages and frequencies of all of your medications. In addition, please make sure you fill out the allergy section completely.

There are some informational pamphlets enclosed regarding our practice and the colonoscopy procedure.

Please return the enclosed forms to our Laurel office as soon as possible so we can facilitate the scheduling of your colonoscopy.

If you wish to have an acknowledgement of our office receiving your screening colonoscopy packet, please address and stamp the enclosed postcard and return it with your packet. After we receive your packet of information and have sent back your postcard, we will review the medical history that you provided us . You will receive a call to schedule your colonoscopy at a convenient time for both you and the physician.

If you should need to reschedule your colonoscopy we ask that you notify us as soon as possible. There is a fee of $150.00 for procedures not canceled within 48 hours.

If you have any questions, or if you need any clarifications regarding the information above, please call us at 301-498-5500 during normal business hours 8:30AM to 5:00 PM.

Sincerely,

Jeffrey S. Garbis, M.D. | Richard M. Chasen, M.D.. | Jeffrey Bernstein, M.D. | Theodore Y. Kim, M.D.
Marvin E. Lawrence II, M.D. | Sean M. Karp, M.D. | Priti Bijpuria, M.D.

03/10/16 gg

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www.CapitalDigestiveCare.Com/mdd

PATIENT INFORMATION Date: ________________________

Patient Information:

Patient Name:	Patient Date of Birth:
Patient Address:	City, State, Zip
Home Phone:	Work Phone:
Cell Phone:	Sex: M F
Height:	Weight:
Age:	Marital Status: Single Married Other
Social Security #:	Email Address:
Patient Employer:	Occupation:

Spouse's Information

Spouse's Name:	Spouse's Date of Birth:
Spouse's Social Security #:	Spouse's Employer:
Spouse's Work Phone:	Spouse's Cell Phone:

Emergency Contact Information:

Emergency Contact Name and Number:

Physician Information:

Primary Care Physician:	Referring Physician:

Primary Insurance:

Insurance Co. Name:	Phone #:
Address:	City, State, Zip:
Name of Policy Holder:	Social Security #:
Relationship to pt:	Date of Birth:
Insurance ID #:	Insurance Group #:

Secondary Insurance:

Insurance Co. Name:	Phone #:
Address:	City, State, Zip:
Name of Policy Holder:	Social Security #:
Relationship to pt:	Date of Birth:
Insurance ID #:	Insurance Group #:

*****TO BE COMPLETED IF PATIENT IS A MINOR*****

Responsible Party:	Phone #
Address:	City, State, Zip:
Employer:	Work Phone:

Communications Notification

Email address (please print):____

Telephone: (Home)____________________(Mobile)_________________________

Capital Digestive Care employs a number of different resources for the purpose of contacting you to deliver important information. Your privacy is important to us and we will not share or sell your information to any third-party vendor except when required for legal and debt collection purposes. Listed below are examples of some of the reasons we may need to reach you using the information we collect at the time of registration (for new patients) or have on file (for established patients), which may include your email address, home or mobile telephone number.

Patient Portal Access: If you choose to create an account, you will be able to update your personal information before or after your appointment, view certain test results and send messages to your doctor and/or doctor's office.

Practice Announcements: These may include new physician or provider announcements or provider retirement/relocation notifications.

Customer Service Improvements: We are always evaluating applications to improve our service to you, including solutions to improve appointment scheduling, appointment reminders and procedure preparation. As the applications become available, you may receive a notification or registration invitation.

Digestive Health Information: This may include information on new treatments or clinical research trials, notification of educational seminars on specific digestive health topics or other relevant information.

Collection Activity: If your account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on your account. You may request the removal of your mobile number for this purpose by providing written notification to Capital Digestive Care, ATTN: Billing Manager, 12510 Prosperity Drive, Suite 200, Silver Spring, MD 20904.

Patient Name (please print) ____ (revised 03-10-16 gg)

Patient Signature ____________________________________**Date:** __________________

Complete Patient History Form

Name:____Date of Birth:______________

The following information is **very important to your health**. Please take time to fully and completely fill out this important information. We are counting on you!

- **Reason for visit**____

____

Race

○ White/Caucasian	○ Black or African American	○ Asian	○ Hispanic or Latino
○ American Indian or Alaska Native	○ Native Hawaiian or Other Pacific Islander	○ Mixed	○ Other
○ Unknown	○ Patient Declines to provide information		

Ethnicity

○ Hispanic or Latino	○ Not Hispanic or Latino	○ Patient Declines to provide information

Gender

○ Male	○ Female	○ Other

Preferred Language

○ English	○ Spanish	○ Other______________

Contact Preference

○ Letter	○ Other____________________________________

- **What pharmacy do you want us to use for any medications that are prescribed?**

Pharmacy: ____

____

Allergies

○ Patient has no known allergies	○ Patient has no known **DRUG** allergies	○ Adhesive tape	○ Codeine Sulfate
○ Erythromycin	○ Latex	○ IV Contrast	○ Penicillins
○ Sulfa	○ Shellfish	○ Other____________	○ Other____________

Complete Patient History Form

Name:____ Date of Birth:______________

Current Medications (include any Over-the-counter medications and any supplements you are currently taking)

o None

Name	Dose	How taken

Immunizations

o None	o Flu vaccine When:____________________	o Hepatitis A When:____________________
o Hepatitis B When:____________________	o Pneumovax When:____________________	o TB Skin test When:____________________

Diagnostic Studies

o None	o Colonoscopy When:____________________	o Endoscopy/EGD When:____________________
o CT Scan Abdomen/Pelvis When:____________________	o MRI of Abdomen/Pelvis When:____________________	o ERCP When:____________________

Previous Procedures/Surgeries

o None	o Gallbladder removed	o Appendectomy	o Colon resection	o Small Bowel resection
o Exploratory Abdominal Surgery	o Gastric Bypass Surgery	o Lap Band Surgery	o Hemorrhoid Surgery	o Hemorrhoid Banding
o Abdominoplasty	o Hysterectomy	o Tubal Ligation	o Mastectomy	o Pacemaker Placement
o Defibrillator Placement	o Coronary Artery Bypass Graphing (CABG)	o Abdominal Aortic Aneurysm (AAA) Repair	o Heart Valve Replacement /Surgery	o Cardiac Catherization /Stent
o Joint Replacement	o Back Surgery	Other______________		Other ____________________

Complete Patient History Form

Name:______________________________ Date of Birth:______________

Past or Present Medical History

- **Gastroenterology/Hepatology**

○ Colon polyps	○ Colon cancer	○ Irritable Bowel Syndrome	○ Diverticulitis
○ Crohn's Disease	○ Ulcerative Colitis	○ GERD /Reflux	○ Barrett's Esophagus
○ Ulcer Disease	○ Hepatitis B	○ Hepatitis C	○ Fatty Liver Disease
○ Cirrhosis/Liver	○ Celiac Disease	○ Bowel Obstruction	○ Pancreatitis
○ Anemia in the past	○ Other ________	○ Other ________	○ Other ________

- **Cardiology**

○ Coronary Heart Disease	○ Heart Valve Disease	○ Congestive Heart Failure	○ Heart attack
○ High Blood Pressure	○ Atrial Fibrillation	○ Vascular Disease	○ High Cholesterol
○ Stroke	○ TIA (mini stroke)	○ Other ________________	

- **Pulmonary**

○ C.O.P.D.	○ Asthma	○ Sleep Apnea
○ Blood Clots (leg)	○ Blood Clots (lung)	

- **Other**

○ Anxiety Disorder	○ Arthritis	○ Bipolar Disorder	○ Body Piercings
○ Breast Cancer	○ Current Pregnancy	○ Depression	○ Diabetes
○ Fibromyalgia	○ Gout	○ HIV Exposure	○ HIV Infection
○ Hypothyroidism	○ Kidney Disease	○ Kidney Stones	○ Lung Cancer
○ Ovarian Cancer	○ Other Cancer	○ Prostate Cancer	○ Recurrent Infections
○ Seizures	○ Skin Cancer	○ Tattoos	Other__________

Complete Patient History Form

Name:____ Date of Birth:______________

Social History

○ Single	○ Married	○ Divorced	○ Separated
○ Widowed	○ Civil Union	○ Unknown	○ Other

I drink alcohol:	**I drink caffeine:**	**I use tobacco:**	**My drug use:**	**I exercise:**
____None _____Less than 7 per week _____More than 7 per week	(coffee, tea, cola, or other caffeinated drinks) _____None _____Occasionally _____Daily	(Circle) Cigarettes Cigars Chewing tobacco __Every Day __Only some days __Former smoker __Never smoked __Smoker, Current status unknown __Unknown if ever smoked	_____None _____IV or inter-nasal drugs **currently** _____IV or inter-nasal drugs **in the past**	___None ___I exercise routinely

Family History

- ○ No knowledge of family history
- ○ **No one in my family has a history of**:

○ Celiac Sprue	○ Colon polyps	○ Gallbladder Disease
○ Liver Disease	○ Stomach Cancer	○ Colon Cancer
○ Crohn's Disease	○ Inflammatory Bowel Disease	○ Polyps
○ Ulcerative Colitis		

- ○ **Someone in my family has a history of**: (please check all that apply)

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Colon Cancer						
Colon Polyps						
Crohn's Disease						
Gallbladder Disease						
Liver Disease						
Ulcerative Colitis						
Stomach Cancer						

Complete Patient History Form

Name:______________________________ Date of Birth:______________

Review of Systems….What are your current symptoms today? (check all that apply):

Allergic/Immunologic
- allergic reactions ○
- current infections ○

Cardiovascular
- chest pain ○
- irregular heart beat ○
- rapid heart rate/palpitations ○
- ankle swelling ○

Constitutional
- fever ○
- loss of appetite ○
- weight loss ○

ENMT
- nose bleeds ○
- loss of vision ○
- hoarseness ○
- mouth sores ○

Endocrine
- excessive thirst ○
- heat or cold intolerance ○

Gastrointestinal
- abdominal pain ○
- abdominal swelling ○
- change in bowel habits ○
- constipation ○
- diarrhea ○
- gas ○
- heartburn ○
- nausea ○
- rectal bleeding ○
- stomach cramps ○
- vomiting ○
- difficulty swallowing ○
- yellowing of skin ○

Genitourinary
- blood in urine ○
- recent darkening of urine ○

Hematologic/Lymphatic
- easy bruising ○
- anemia ○

Integumentary
- itching ○
- rashes ○
- rashes/hives ○

Musculoskeletal
- back pain ○
- joint pain/arthritis ○

Neurological
- dizziness ○
- fainting ○
- frequent headaches ○
- vertigo ○
- memory loss/confusion ○

Psychiatric
- depression ○
- anxiety/panic attacks ○

Respiratory
- wheezing ○
- frequent cough ○
- shortness of breath when at rest ○

NOTICE OF PRIVACY PRACTICES

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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Center Leader

I,_____________________________________,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:______________________Date:______

If not signed, reason why acknowledgement was not obtained:____________________________

Staff Witness seeking acknowledgement
____________________________Date:______

There's a new way to communicate with your doctor and their office.

In addition to calling us during regular business hours, we now have an online patient portal that allows you 24/7 access from anywhere.

gPortal will allow you to

- Send messages to your doctor or their staff (all messages left will be processed the next business day)
- Request appointments
- Check your laboratory results
- Request prescription refills
- Update your personal and medical records

If you are interested in signing up for our gPortal, please complete the information below and an invitation will be emailed to you. **Your emailed invitation will be titled "Myportal-no reply with Capital Digestive Care in the subject." Be sure to check your spam and junk email for the invitation. If you don't receive your invitation within a couple days let us know and we'll resend it.**

Name: ____

Date of Birth: ____

Email Address: ____

Date: ____

Be sure to ask a staff member for a gPortal brochure. We look forward to communicating with you online. 03-10-16 gg

DIRECTIONS TO AMBULATORY ENDOSCOPY CENTER OF MARYLAND:

Laurel Office:
Laurel Medical Arts Pavilion
7350 Van Dusen Rd.
Suite 230
Laurel, MD 20707
Telephone: 301-498-5500
Fax: 301-498-7346
Business Office: Suite 250

From the South:

- Take I-95 North toward Baltimore
- Take exit 33A, which is Laurel Route 198.
- As you exit off ramp, stay in your far right lane.
- At intersection make right turn onto Van Dusen Road.
- Stay straight on Van Dusen.
- At 5th traffic light turn right into Laurel Regional Hospital's driveway. Our building sits to the right of of the hospital.

03-10-16

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Benefits

With gPortal, you can...

- Request appointments
- Check your results
- Send a message to our practice
- Update your personal and medical records
- Log-on 24/7- access from anywhere

gPortal, the link between you and our practice

How to Start...

Recommended for
Internet Explorer (8 or higher), or Mozilla-Firefox.

Create
your username and password
today!

Start **taking an active role** in your healthcare!

Contact...

CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Maryland Digestive Disease Center
Laurel, MD
Columbia, MD
Takoma Park, MD
301-498-5500

Now we have an interactive **online portal** designed **specifically for you,** our valued **patient**

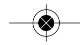
Introducing...

by

Capital Digestive Care

! If you need immediate medical attention, please call 911 or go to your nearest hospital.

Trifold Brochure-gPortal-Practices_Trifold Brochure-gPortal 12/11/12 4:29 PM Page 2



How do I register?

Step 1: You will receive an invitation email from our practice with a link and unique ID that will take you through the registration process.

Step 2: Click on the link in the invitation email to create a unique user ID and password.

Step 3: Once registered, complete your medical, family and social history.

You may send a message directly to our practice to update additional fields (ex. Address, Insurance information, etc).

Step 4: Click submit to send your information directly to our office

How do I...

Send a message to my Doctor's office?

- Click on the message tab.
- Click "new" and compose your message.
- Remember to hit send.

Receive messages through gPortal?

- You will receive a notification email when you have a message waiting in ***gPortal***.
- Click on the message tab.
- Click on "new messages" to view your messages.

Update my personal information?

- Click "update" button.
- Click on the "personal info" tab.
- Change the information you want

How do I...

Reset my password?

- Click on the "change password" tab.
- Enter username, DOB and registered email address.

Frequently Asked Questions

Q: Can I schedule my appointment online through gPortal?

A: You may send a request to schedule your appointment and our practice will contact you.

Q: Does gPortal allow me to send a message directly to my physicians office?

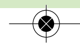
A: Yes, you may send a message directly to our office through gPortal. We will make sure your message reaches the correct person so that your question is answered.

Q: Can I refill my prescriptions through gPortal?

A: No, you must go directly through your pharmacy in order to refill your prescription.

Q: What do I do if my account is locked due to too many failed log-in attempts?

A: Click on the change password tab and follow the instructions to create a new password.



who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

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, Recieve care in a safe setting,
Be free from all forms of abuse or harassment

Advance Directives

You have the right to information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will be provided upon request.

The surgery center is not an acute care facility; therefore, regardless of the contents of any advanced directive or instructions from a health care surrogate, if an adverse event occurs during treatment, 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 they have been provided to the surgery center, a copy of the patient's Advanced Directives will be sent to the acute care facility with the patient.

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 those wishes.

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:

KIM WILSON, RN, BSN - Center Director
7350 Van Dusen Road Suite 230
Laurel, MD 20707
(voice) 301-498-5500 ext. 117 (fax) 301-604-5956

Accreditation Association for
Ambulatory Health Care (AAAHC)
5250 Old Orchard Road, Suite 250
Skokie, IL 60077
Tel: 847/853.6060
Fax: 847/853.6118 Email: info@aaahc.org

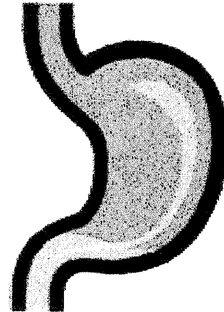
You may contact your state representative to report a complaint;
www.gov.state.md.us/

Office of Health Care Quality
Department of Health and Mental Hygiene
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228
Phone Number: (410) 402-8000
Toll-free: 1-800-492-6005
Email: ohcqweb@dhmh.state.md.us

State website -http://www.dhmh.maryland.gov/
Sites for address and phone numbers of regulatory agencies: **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 AmSurg Corporation and in part by the following physicians: Jeffrey Garbis, MD; Richard Chasen, MD; Jeffrey Bernstein, MD; Theodore Kim, MD; Marvin Lawrence MD; Priti Bijpuria, MD and Sean Karp, MD. 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.

Patient Rights, Responsibilities and Notification of Physician Ownership



AEC

AMBULATORY ENDOSCOPY CENTER
OF MARYLAND, LLC.
7350 Van Dusen Road, Suite 230
Laurel, Maryland 20707
301-498-5500 (phone) 301-604-5956 (fax)
TTY Users Call Maryland Relay #711

As a patient of the **AMBULATORY ENDOSCOPY CENTER OF MARYLAND**, you have the right to receive the following information in advance 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 treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

•To receive consideration and respectful care from competent personnel in a clean and safe environment. To be free from mental, physical, sexual and verbal abuse, neglect, exploitation and free from use of unnecessary restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

•To understand the indications for the procedure. To receive all the information they need to give informed consent for any procedure, including the possible risks and benefits of the procedure.

•To receive complete information regarding diagnosis, planned treatment and prognosis, as well as alternative treatments/procedures and the possible risks/side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.

•To participate in all decisions involving health care, except when such participation is contra-indicated for medical reasons.

•To refuse treatment in accordance with laws and regulations, to leave the facility even against the advice of his/her physician and to be told what affects this may have on their health.

•To change their provider to another available provider.

•To assure safe use of equipment by trained personnel.

•(If applicable) Be advised as to the absence of malpractice coverage.

•To be provided privacy, confidentiality and integrity of all information and records regarding their care.

•To be provided privacy, safety and security of self and belongings during the delivery of patient care service.

•To have the right to access information contained in their medical record. To approve or refuse the release of their medical records except when it is required by law and to ask for an accounting of such.

•To be aware of fees for service and the billing process.

•To complain or file a grievance without fear of reprisals about the care and services that they are receiving.

•Has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.

•The right to inquire about the credentials of health care professionals.

•The right to appropriate assessment and management of pain.

•The right to continuity of health care and to know in advance the time and location of appointment, as well as the physician providing the care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.

•To be informed if the facility has authorized other healthcare and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and functions of this institution and to refuse to allow their participation in the patient's treatment.

•To request and receive information on Advanced Directives and the Center's policy on honoring them.

•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.

•To be assured that in the event of needed long-term care; this organization will provide the mechanisms to help advance the development of continuing quality care for those patients who require it.

PATIENT'S RESPONSIBILITIES:

•To provide accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, any medications including over the counter products and any allergies or sensitivities.

• To inform the provider about any living will, medical power of attorney or other directive that could affect their care.

•To follow the treatment plan prescribed by provider and for asking questions when they do not understand something regarding their care or treatment.

•For assuring that the financial obligations for health care rendered are paid in a timely manner.

•For their actions if they should refuse a treatment or procedure; or if they do not follow or understand the instructions given them by the physician or Center employee.

•For keeping their procedure appointment. If they anticipate a delay or must cancel, they will notify the Center as soon as possible.

•For the disposition of their valuables, as the Center does not assume this responsibility.

•For showing respect and consideration to other people and property.

•Patients are responsible for **Arranging Transportation** to and from the facility by a responsible adult.

•To assure there are no children left unattended in the facility at any time.

If you need a translator:

If you will need a translator, **please let us know** and one will be provided for you. If you have someone

The Ambulatory Endoscopy Center of Maryland

is a state-of-the-art facility that allows us to perform gastroenterologic procedures in an outpatient setting. We are able to provide high quality care in a patient-friendly environment. This allows us to accommodate our patients more effectively and efficiently.

Our center is AAAHC (Accreditation Association for Ambulatory Health Care, Inc.) accredited and Medicare Certified.

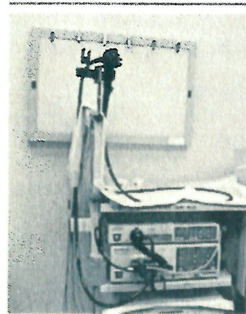
Our Physicians and nursing staff are ACLS (Advanced Cardiac Life Support) certified.

If requested, information regarding Advance Directives/Living Wills is available at this office.

Due to limited waiting room space, please bring only your driver to accompany you – if possible.

Procedures Performed In Our Center

- Colonoscopy
- Polypectomy
- Liver Biopsy
- Upper GI Endoscopy
- Esophageal Dilations
- Removal of Foreign Bodies
- Biopsies of the GI Tract
- Control of Gastrointestinal Hemorrhage
- Gastrostomy Tube Placement and Replacement
- Paracentesis
- Enteroscopy
- Capsule Endoscopy



Common Medical Problems That Are Evaluated In Our Center

- Colon Cancer Screening
- Removal of Colonic Polyps
- Abdominal Pain Not Responding to Appropriate Therapy
- Heartburn Persisting on Appropriate Therapy
- Trouble Swallowing
- Testing for Helicobacter Pylori
- Evaluation of Inflammatory Bowel Disease
- Evaluation of Elevated Liver Tests
- Causes of Gastrointestinal Bleeding
- Testing for Causes of Intractable Diarrhea
- Weight Loss
- Hemorrhoids

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 treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive consideration and respectful care from competent personnel in a clean and safe environment. To be free from mental, physical, sexual and verbal abuse, neglect, exploitation and free from use of unnecessary restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
- To understand the indications for the procedure. To receive all the information they need to give informed consent for any procedure, including the possible risks and benefits of the procedure.
- To receive complete information regarding diagnosis, planned treatment and prognosis, as well as alternative treatments/procedures and the possible risks/side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.
- To participate in all decisions involving health care, except when such participation is contra-indicated for medical reasons.
- To refuse treatment in accordance with laws and regulations, to leave the facility even against the advice of his/her physician and to be told what affects this may have on their health.
- To change their provider to another available provider.
- To assure safe use of equipment by trained personnel.
- (If applicable) Be advised as to the absence of malpractice coverage.
- To be provided privacy, confidentiality and integrity of all information and records regarding their care.
- To be provided privacy, safety and security of self and belongings during the delivery of patient care service.
- To have the right to access information contained in their medical record. To approve or refuse the release of their medical records except when it is required by law and to ask for an accounting of such.
- To be aware of fees for service and the billing process.
- To complain or file a grievance without fear of reprisals about the care and services that they are receiving.
- Has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.
- The right to inquire about the credentials of health care professionals.
- The right to appropriate assessment and management of pain.

- The right to continuity of health care and to know in advance the time and location of appointment, as well as the physician providing the care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- To be informed if the facility has authorized other healthcare and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and functions of this institution and to refuse to allow their participation in the patient's treatment.
- To request and receive information on Advanced Directives and the Center's policy on honoring them.
- 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.
- To be assured that in the event of needed long-term care; this organization will provide the mechanisms to help advance the development of continuing quality care for those patients who require it.

Patient's Responsibilities:

- To provide accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, any medications including over the counter products and any allergies or sensitivities.
- To inform the provider about any living will, medical power of attorney or other directive that could affect their care.
- To follow the treatment plan prescribed by provider and for asking questions when they do not understand something regarding their care or treatment.
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- For showing respect and consideration to other people and property.
- Patients are responsible for Arranging Transportation to and from the facility by a responsible adult.
- To assure there are no children left unattended in the facility at any time.

We encourage you to visit us on the web at www.endocentermaryland.com or www.capitaldigestivecare.com/MDD for information on:

- Medical Staff Profiles
- Procedures Performed
- Digestive Disorders
- Patient Information
- Forms and Screening Packets
- Preps for Procedures
- Office Locations
- Directions
- Links to Digestive Resources
- Contacts

Directions to the Ambulatory Endoscopy Center of Maryland:

Take I-95 to exit 33A, Route 198 - Laurel. Turn right on Van Dusen Road. At 5th traffic light, make a right into Laurel Regional Hospital's driveway. The Medical Arts Pavilion is on the right. Report to Suite 230.

Ambulatory Endoscopy Center

of Maryland, Inc.

Partnered with AmSurg Corporation

Affiliated with Maryland Digestive Disease Center, a division of Capital Digestive Care & AmSurg Corporation.

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7350 Van Dusen Road, Suite 230
Laurel, MD 20707
301-498-5500
800-735-2258 TTY

Capital Digestive Care, LLC

Ambulatory Endoscopy Center of Maryland
A Division of AmSurg Corporation

CapitalDigestiveCare.com/mdd

Patient Billing Explanation

Dear Patient:

You are scheduled to have an endoscopic procedure at Ambulatory Endoscopy Center of Maryland. The procedure will be performed by one of the Capital Digestive Care GI physicians. During the procedure you may receive sedation administered by one of the Anesthesia Group CRNA's (Certified Registered Nurse Anesthesiologists).

Frequently during the endoscopy your doctor will take a biopsy(s). If a biopsy is obtained, the specimen will be processed at the Capital Digestive Care Pathology Lab and will be interpreted by one of their pathologists.

Your procedure will generate the following different charges to your insurance or to you, if you do not have insurance:

Professional Fee: This is the fee from the Capital Digestive Care, LLC, GI physician that performed your procedure.

Facility Fee: This is the fee from Ambulatory Endoscopy Center of Maryland where your procedure is going to be performed.

Anesthesia Fee: This is the fee from Corridor Anesthesia, LLC for the services provided by the CRNA.

Pathology Fee: This is the fee from Capital Digestive Care Pathology for the interpretation of the biopsy by one of the pathologists.

If you have any questions prior to your procedure about the fees generated by any of the groups, please call Ambulatory Endoscopy Center of Maryland at 301-498-5500.

Your explanation of benefits (EOB) can be confusing. The following information may help you to understand this document:

Total Charges: This is the total amount billed to insurance. This charge will be processed by the payer according to its contract with the facility.

Allowed Amount: This is the total amount the facility expects to receive from insurance and/or patient combined. (It is also called the negotiated amount or expected amount).

Payable amount: This is the amount that the primary insurance will pay.

Patient responsibility: This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the "patient responsibility", depending on your contract.

3-10-16 gg