CONSENT TO RELEASE OF
PATIENT INFORMATION

West Georgia Gastroenterology Associates, P.C. ("WGG") is a medical practice specializing in (i) the diagnosis and treatment of disorders of the digestive system and liver, and (ii) colorectal cancer screening. WGG's physicians are also affiliated with West Georgia Endoscopy Center, LLC ("WGEC"). WGEC is an ambulatory surgery center at which physicians perform procedures that allow them to examine the interior of a patient's digestive system, for purposes of diagnosing digestive system disorders.

As a patient of WGG, you will provide WGG with a variety of health and other personal information to enable your physician to diagnose and treat your medical conditions. Also, in the course of providing treatment, WGG will collect additional information related to your health. For purposes of this Consent Form, the information that you provide to WGG and the information that WGG collects in the course of providing treatment is referred to as the "Personal Health Information".

Should your physician determine that you require a procedure that will be performed at WGEC, and should you consent to the performance of that procedure, then WGEC will need the Personal Health information that is in the possession of WGG.

BY SIGNING BELOW, YOU ARE AUTHORIZING WGG TO SHARE YOUR PERSONAL HEALTH INFORMATION WITH WGEC IN THE EVENT THAT YOU ARE SCHEDULED IN THE FUTURE TO UNDERGO A PROCEDURE AT WGEC. THIS WILL ELIMINATE THE NEED FOR YOU TO PROVIDE WGEC WITH THE SAME PERSONAL HEALTH INFORMATION THAT YOU HAVE ALREADY PROVIDED TO WGG.

I, ____________________ (PATIENT NAME), HEREBY AUTHORIZE WGG TO RELEASE MY PERSONAL HEALTH INFORMATION TO WGEC IN THE EVENT THAT I AM SCHEDULED AT A FUTURE DATE TO UNDERGO A PROCEDURE AT WGEC. IF, AT A FUTURE DATE, I AM SCHEDULED TO UNDERGO A PROCEDURE AT WGEC, WGG SHALL NOT BE REQUIRED TO OBTAIN ANY FURTHER CONSENT FROM ME BEFORE SHARING MY PERSONAL HEALTH INFORMATION WITH WGEC.

Signature of Patient or Personal Representative

____
(Signature)

________________________________, Patient or Personal Representative
(Print Name)

____
(Date)

FINANCIAL INFORMATION

OUR OFFICE POLICY IS TO COLLECT PAYMENT BEFORE SERVICES ARE RENDERED. ALL COPAY, DEDUCTIBLE, AND COINSURANCE AMOUNTS SHOULD BE PAID TO THE RECEPTIONIST AT CHECK-IN.

All professional services rendered are charged to the patient. We will assist you with insurance reimbursement; however the patient is ultimately responsible for all fees regardless of insurance coverage. It is our policy to request payment at the time of service unless other arrangements have been made in advance. If you have questions about fees, please ask the receptionist before being seen.

I assign to West Georgia Endoscopy Center, LLC. all payments for medical services including major medical benefits rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize West Georgia Endoscopy Center, LLC. to furnish information to insurance carriers, physicians, or hospitals concerning my illness and treatments. I authorize any physician, hospital, or medical care facility to provide all information on medical history and treatment to West Georgia Endoscopy Center, LLC., and I authorize photocopies of this form to be as valid as the original. In the event that my records need to be faxed for any reason and are accidentally misdirected, I release West Georgia Endoscopy Center, LLC. from any liability. I have read and understand the above and give West Georgia Enodoscopy Center, LLC. permission to treat me/my child.

SIGNED:____________________________________ DATE:____________________

The Doctors and Staff of West Georgia Endoscopy Center, LLC want you to know how we will protect your private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act("HIPPA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give Patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans, and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil and criminal penalties: and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosure to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any review and keep for your records. Thank you for your cooperation.

Acknowledge of receipt of Notice of Privacy Practices

Patient Name:____

(please print)

Signature of Patient or Personal Representative:

______________________________________ Date: ____________________

Persons to Whom Information may be disclosed

____

Name of Person/Relationship

____

Name of Person/Relstionship

WEST GEORGIA ENDOSCOPY CENTER, LLC
PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

1. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration, and dignity.
2. Patients shall receive assistance in a prompt, courteous, and responsible manner.
3. Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
4. Patients have the right to know the identity and status of individuals providing services to them.
5. Patients have the right to change providers if they so choose.
6. Patients, or legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if know, and follow-up care. All patients will sign an informed consent from after all information has been provided and their questions have been answered.
7. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
8. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
9. Patients have the right to express complaints about the care they have received and to submit their grievance to the Clinical Supervisor. The Clinical Supervisor will complete an "Adverse Event Notification" and bring the issue to the attention of the Medical Director in a timely manner, so that the grievance may be addressed. West Georgia Endoscopy Center is responsible for providing the patient or his/her designee with a written response within 30 days, indicating the findings of the investigation.
10. Patients have the right to be provided with information regarding emergency and after hours care.
11. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
12. Patients have the right to a safe and pleasant environment during their stay.
13. Patients have the right to have procedures performed in the most painless way possible.
14. Patients have the right to develop Advance Directives, however, West Georgia Endoscopy Center LLC, does not accept Advanced Directives.
15. Patients have the right to be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payments.
16. Patients have the right to approve or refuse the release or disclosure of his/her medical record to a healthcare facility, except as required by law or third party payment contract.
17. Patients have the right to be informed that West Georgia Endoscopy Center is owned and operated by Howard Seeman, M.D.
18. Patients have the right to exercise his or her rights without being subjected to discrimination or reprisal.
19. Patients have the right to be free from all forms of abuse or harassment.

Patient Responsibilities

1. Patients are responsible for providing complete and accurate medical histories, including providing information on all current medications.
2. Patients are responsible for providing an adult to transport them home after the procedure.
3. Patients are responsible for keeping all scheduled pre-and post-procedure appointments, and complying with treatment plans to help ensure appropriate care.
4. Patients are responsible for reviewing and understanding the information provided by the Physician or Nurse.
5. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
6. Patients are responsible for providing insurance information at the time of their visits, and notifying the receptionist of any changes in insurance coverage or medical information.

7. Patients are responsible for paying all charges for co-payments, co-insurance, and deductibles on non-covered services at the time of the visit, unless other arrangements have been made in advance.
8. Patients are responsible for treating physicians and staff in a courteous and respectful manner.
9. Patients are responsible for asking questions about their medical care and seeking clarification from the physician of the services to be provided, until they fully understand the care they are to receive.
10. Patients are responsible for following the advice of their provider, and understanding the alternatives and/or likely consequences if they refuse to comply.

Signature:____ Date:______________________

To file a grievance you may contact:

Jim Cooley, Administrator @ 770-214-2800

Georgia Department of Community Health
Office of Regulatory Services
2 Peachtree St.
Atlanta, GA 30303

CMS Office of Inspector General
1-800-447-8477

Office of Medicare Beneficiary Ombudsman
http://www.cms.hhs.gov/center/ombudsman.asp

West Georgia Endoscopy Center, LLC
160 Clinic Avenue
Carrollton, GA 30117

PF-1000 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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of West Georgia Gastroenterology Associates, P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

WEST GEORGIA ENDOSCOPY CENTER, LLC
PATIENT AUTHORIZATION FORM

I request that payment of authorized benefits be made to **WEST GEORGIA ENDOSCOPY CENTER, LLC.** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

DATE:______________________ INITIALS:__________________

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process claims, and any other medical information that is required for any healthcare related utilization review or quality assurance activities, and to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **WEST GEORGIA ENDOSCOPY CENTER, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, and self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me or my financial responsibility for all medical fees and charges incurred by my or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **WEST GEORGIA ENDOSCOPY CENTER, LLC** by any insurance policy, self-insurance program, or other benefit plan.
This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION:____

RELATIONSHIP TO PATIENT IF NOT PATIENT:____

DATE:________________________ INITIALS:_________________________

<u>ALTERNATIVE CONTACT AUTHORIZATION</u>

I do O do not O authorize **WEST GEORGIA ENDOSCOPY CENTER, LLC** to contact me or leave messages for me at my place of work. **DATE:______________ INITIALS:________________**

I do O do not O authorize **WEST GEORGIA ENDOSCOPY CENTER, LLC** to discuss my appointments, medical evaluation, treatment, and results with relatives or other persons as indicated:

Authorized
person/relationship:____
____

DATE:____________________ INITIALS:______________________

I hereby authorize WEST GEORGIA ENDOSCOPY CENTER, LLC to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize that I must call the office to obtain laboratory results.
DATE:_________________ INITIALS:____________________

ADVANCE DIRECTIVES

I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. Also, I acknowledge that I do O do not O have such Advance Directives. If I do not have such Directives at this time, but establish them later, I will provide the Center with a copy.
DATE:_______________ INITIALS:_________________