COLLIER ENDOSCOPY & SUGERY CENTER

3439 Pine Ridge Rd | Naples, FL 34109 | (239) 594-5243
info@collierendoandsurgery.com | collierendoandsurgery.com

Patient Financial Responsibility/Surgery Contract

It has been explained by Collier Endoscopy and Surgery Center that I have been given an estimate of the charges for the proposed surgery. I understand that any additional procedures performed during surgery will be added to this estimate. I also understand that my insurance company will base reimbursement on their usual and customary fee and I will be financially responsible for any balance not paid by insurance. Balance must be paid within 90 days.

Assignment of Benefits:
I authorize assignment of all medical insurance benefits to Collier Endoscopy and Surgical Center for medical services rendered.

I understand that this estimate is for services provided for Collier Endoscopy and Surgery Center only. Additionally, myself, or my insurance company may be billed by anesthesia, pathology, laboratory, and the attending physician for services rendered at Collier Endoscopy and Surgery Center.

Agreement to pay for services:
I agree to pay Collier Endoscopy and Surgery Center for all charges rendered to the patient today and/or any future dates of service in this facility. I understand payment in full and/or co-pay and / or coinsurance is expected at the time services are rendered. I further understand, in the event this account is referred to an agency or an attorney for collection, I will be responsible for all collection fees, interest accrued, attorney's fees, and court fees.

_____ _____

Signature of Patient Date

Collier Endoscopy is actively monitoring the progression of the corona virus (COVID-19) to ensure that we have the most accurate and the up-to-date information on the virus.

I acknowledge the contagious nature of Coronavirus/COVID-19.

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I further acknowledge that Collier Endoscopy and Surgery Center has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I acknowledge that Collier Endoscopy and Surgery Center cannot guarantee that I will not become exposed to and/ or infected with the Coronavirus/COVID-19.

I understand that the risk of becoming exposed to and /or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including but not limited to staff, other Collier Endoscopy and Surgery Center patients and their families.

I voluntarily seek care provided by Collier Endoscopy and Surgery Center and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19

We are vigilant about our need to protect our patients and staff, these measures are not new to us as we seek to minimize risk regularly.

I hereby release and agree to hold Collier Endoscopy and Surgery Center harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of actions, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/ or property that may be caused by any act, or failure to act of the center, or that may otherwise arise in any way in connection with any services received at Collier Endoscopy and Surgery Center.

I understand that this release discharges Collier Endoscopy and Surgery Center from any liability or claim that I, my heirs, or any personal representatives may have against the center with respect to any bodily injury, illness, death, medical treatment, or property damage that may occur.

_____ _____

Patient Signature Date/Time

Temperature upon arrival to CESC: _____ taken by _____(initials)

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Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the par of patients.
You may request a copy of the full text of this law from your health care provider or health care facility.

A summary of your rights

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he OF she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given health care information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare rate
- A patient the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill, and, upon request, to have charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A-patient has the right to know if medical treatment is for experimental research purposes and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him/her and to the appropriate state licensing agency.

A summary of your responsibilities

- A patient is responsible for providing to the health care provider, to the best of his / her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his/her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he/she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for following the treatment plan recommended by the health Care provider.
- A patient is responsible for his or her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care and facility rules and regulations affecting patient care and conduct.

I have received a copy:

_____ _____

Signature **Date/Time**

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Agency for Health Care Administration

To file a health care facility complaint, call (888) 419-3456 / (800) 955-8771 Florida Relay Service (TDD number) or complete the Health Care Facility Complaint Form. Search our FloridaHealthFinder.gov site to see if the facility you have concerns about is one that is regulated by our Agency.

To file a Medicaid fraud and abuse complaint, call (888) 419-3456 / (800) 955-8771 Florida Relay Service (TDD number) or complete the Medicaid fraud complaint form.

Many publications are available for viewing and printing on our AHCA Publications page or directly from FloridaHealthFinder.gov.

For questions or information, you may contact the Agency for Health Care Administration by feedback form or by phone toll-free at (888) 419-3456 / (800) 955-8771 Florida Relay Service (TDD number) or by mail at:

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

The Joint Commission

E-mail: patientsafetyreport@jointcommission.org
Fax: 630-792-5636
Mail: Office of Quality and Patient Safety

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Advance Directive/Living Will

I understand that Collier Endoscopy and Surgery Center's policy does not honor advance directives/living wills, but that it is my right to have an advance directive/living will present in my medical record at the surgery center. I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, CESC will still transfer me the the closest hospital, and provide that institution with a copy of such document and that at that time, the institution to which I have been transferred will make decisions about following any advance directive or living will.

State information and forms to prepare an advance directive, if you decide to have one, can be found at the following website:

http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx

or contact Agency for Health Care Administration
2727 Mahan Drive, M.S. 16
Tallahassee, FL 32308
Tele: 888-419-3456

Or contact

The Joint Commission for Accreditation of Healthcare Organizations (TJC) 800-994-6610

_____ _____

Patient Signature Date

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Lifetime Authorization
Insurance Assignments and Authorization to Release Information and Financial Policy

RELEASE OF INFORMATION: I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third party payer (such as an insurance company or government agency, example; Blue Cross and Blue Shield or Medicare) any medical, psychiatric condition, alcohol, or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with adjudication a claim for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.

MEDICARE/MEDICAID: Patient's authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/ division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance payments pertaining to treatment shall be assigned to the physician treating me.

GUARANTEE OF PAYMENT: I, the below named patient/guarantor, does hereby guarantee payment of all charges incurred for the account of the patient named below. I further agree to waive demand and notice of nonpayment and protest and in case suit shall be brought for the collection hereof, for the same collected upon demand of any Attorney. I agree to pay all cost of collection, including collection fees (25%), reasonable attorney's fee and court cost.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE.

This assignment will remain in effect until revoked by me in writing.

CANCELLED APPOINTMENTS. Patients who do not cancel appointments may be discharged from the practice after the third no show. There will be a $100.00 cancellation fee for all procedures missed or cancelled without 48 hours prior notice.
PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, MasterCard, VISA, Discover, and American Express. We do not accept checks. If a check is sent to our office and it is returned by the back there will be a service charge of $35.00 or 5% of the face value of the check. There is a $50.00 fee for any form to be filled out by the physician.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Please be aware of after 2 statements and 1 phone call to the number on file we have yet to receive payment in full for a past due balance it is possible your account could be sent to a collection agency. We do offer a financial hardship please ask for an application if you believe you may qualify. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third party payer within a reasonable period of time not to exceed 60 days.

ASSIGNMENT AND RELEASE
I, the undersigned, assign directly to Collier Endoscopy and Surgery Center all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of his/her signature on all my insurance submissions.

MEDICARE AUTHORIZATION I request that payment of authorized Medicare benefits be made to either me or on my behalf to Collier Endoscopy and Surgery Center for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature_____ Date_____

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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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

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Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing

purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as

well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer, Gina Vaughn, RN at the following phone number for any questions:

Phone number: 239-260-7324

Effective Date

The effective date of this revised Notice of Privacy Practices is March 26, 2013.

Collier Endoscopy and Surgery Center
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239-594-5243 www.collierendoandsurgery.com

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Collier Endoscopy and Surgery Center a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Collier Endoscopy and Surgery Center privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE **DATE**

Or Personal Representative

Collier Endoscopy and Surgery Center
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I, the undersigned patient, hereby agree as follows. In the event that I have, at any time, a credit balance (i.e., money that is owed to me) with Collier Endoscopy and Surgery Center, and at the same time I owe Advanced Gastroenterology of Naples or Pain Management Center, I instruct Collier Endoscopy and Surgery Center to pay that credit balance to Advanced Gastroenterology of Naples and/or Pain Management Center to reduce my balance to those entities.

I understand that I will receive notification from Advanced Gastroenterology of Naples and/or Pain Management Center as to how much money has been applied to my balance and what my outstanding balance is after that credit balance has been applied. I also understand that if the amount I owe to Advanced Gastroenterology of Naples and/or Pain Management Center is less than my credit balance with Collier Endoscopy and Surgery Center, that Collier Endoscopy and Surgery Center will refund the remaining balance to me.

_____ _____

Patient Signature Date

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PATIENT EMERGENCY CONTACT INFORMATION SHEET

Patient Legal Name: _____
Last First MI

Date of Birth: _____ SS#: _____

Local Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Additional Phone Number: _____

Primary Care Physician: _____

Referring Physician: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

May we disclose information to this person regarding your medical condition? **YES** **NO**

_____ _____
Patient Signature Date/Time

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Patients and prospective patients should be aware that services may be provided in this health care facility by the facility as well as by other health care providers who may separately bill the patient and who may or may not participate with the same health insurers or health maintenance organizations as the facility, as applicable.

There are multiple elements to your care provided at Collier Endoscopy and Surgery Center. You may receive a bill or explanation of benefits from your insurance for Naples Pathology; Anesthesia and the physicians practice: Advanced Gastroenterology of Naples, Dr. Nanavati; or Pain Management Center of Naples, Dr. Moorthy.

Patients and prospective patients should contact each health care practitioner who will provide services in the ASC to determine the health insurers and health maintenance organizations with which the health care practitioner participates as a network provider or preferred provider

Dr. Nanavati	4760 Tamiami Trail N #27 Naples, FL 34103	239-593-9599
Dr. Moorthy	4760 Tamiami Trail N #27 Naples, FL 34103	239-593-9594
Anesthesia	4760 Tamiami Trail N #27 Naples, FL 34103	239-594-5243
Naples Pathology	P.O. Box 166324 Miami, FL 33116	866-512-6639

All insurance plans have different benefits as well as different financial obligations; we will verify your coverage as best we can. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits; we will assist as best as we can.

Please feel free to contact one of Collier Endoscopy and Surgery Center billing representatives by calling 239-594-5243 for any questions concerning your itemized statement or bill.

There will be a $100.00 fee for cancelled procedures without 24–48-hour notice.

Owner Disclosure:
Dr. Nanavati and the Prathima Moorthy Irrevocable Trust has ownership interest in Collier Endoscopy and Surgery Center.

_____ _____

Patient Signature Date