Central Massachusetts AEC
105 Erdman Way
Leominster, MA. 01453
978-840-6767

PATIENT INFORMATION CONFIDENTIAL

EMERGENCY CONTACT_____ PHONE_____

Generally the day after your procedure or several days thereafter we make a courtesy phone call to check on your status after your procedure. Please answer the following questions accordingly:

MAY WE LEAVE FOLLOW-UP MESSAGES ON YOUR ANSWERING MACHINE/VOICE MAIL?	YES	NO
WHEN WE CALL, MAY WE DISCUSS YOUR PROCEDURE WITH ANYONE OTHER THAN YOU?	YES	NO
DO YOU HAVE AN ADVANCE DIRECTIVE?	YES	NO
DID YOU RECEIVE THE RIGHTS AND RESPONSIBIITIES INFORMATION SHEET PRIOR TO PROCEDURE?	YES	NO

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Feinberg, Dr Yu, Central Massachusetts Ambulatory Endoscopy Center (CMAEC) for services rendered by the physicians or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr Feinberg and Dr Yu to use or disclose my medical or incidental information, which specifically identified me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary if I refuse to sign this consent CMAEC can refuse to treat me.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

I have been given a copy of the Notice of Privacy Standards ("Notice"), which more fully describes the uses, and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notifying CMAEC, in writing, but if I revoke my consent, such revocation will not affect any actions that CMAEC took before receiving my revocation.

I understand that CMAEC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that CMAEC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that CMAEC does not have to agree to such restrictions, but that once such restrictions are agreed to, CMAEC must adhere to such restrictions.

A photocopy of these assignments shall be valid as the original.

PATIENT SIGNATURE_____ DATE_____

PARENT/GUARDIAN_____ RELATIONSHIP TO PATIENT_____

DRIVER NAME_____ PHONE #_____

PATIENT'S EMAIL ADDRESS_____ WITNESS_____

Our Commitment to Each Other:
Patient & Provider's Mutual Responsibilities During COVID

In the setting of the current COVID-19 pandemic, it is critical to our patients' health and successful surgical/procedural outcomes to avoid COVID-19 infection after surgery/procedure.

In times of restrictive social isolation "Stay Home, Stay Safe" programs, the very act of leaving home and coming to any public place carries some inherent risk of SARS-CoV-2 exposure, and then COVID-19 disease. Therefore, it is incumbent on physicians, their teams, and their facilities to provide as safe and sanitary a patient surgical/procedural experience as possible to achieve currently.

Patient, caregiver, and family/"dwelling partner" actions and behavior are even more critical to prevention of COVID-19 during the postoperative recovery phase of care, as it lasts much longer than just the day of surgery/procedure.

An infection of COVID-19 in a patient recovering from surgery/procedure not only threatens their life and health, but can lead to postoperative complications, and have permanent damaging effect on the outcome of their surgery/procedure. Therefore, a COVID-19 infection is critical to prevent.

The, simplest, most scientifically-proven prevention methods to date include:

- Social distancing of *at least* 6 feet between people at all times if possible.
- Minimizing interaction with other people except as necessary (e.g. medical follow-up and physical therapy visits).
- Avoid any close contact with people who are sick with COVID-19 symptoms (e.g. cough, fever, body aches, and general fatigue).
- Frequent hand washing or sanitizing for at least 20 seconds each time, especially before and after eating or touching the face or nose, putting on and taking off face masks or coverings, and necessary touching of others (e.g., patient medical care, changing surgical dressings, etc.).
- [Ophthalmology] Wash hands before and after any time eye drops are administered.
- Regular and frequent cleansing of high-use surfaces (e.g. counters, doorknobs, drawer, cupboard, and refrigerator handles) with soap, bleach, or germicidal/virucidal cleansers.
- Wearing a face mask or cloth covering nose and mouth when outside your home <u>at all times</u>.

<u>Patient Acknowledgment:</u>

I hereby acknowledge reviewing this document fully, and understanding its contents. I hereby agree to abide by the COVID-19 prevention measures listed above for at least the first 2 weeks after my surgery/procedure. I agree to ask my caregivers, "dwelling partners," and those who come in near contact with me to do the same.

Patient Signature X_____Date_____Time _____

PATIENT LABEL HERE

NOTICE OF PRIVACY PRACTICES

Central Massachusetts Ambulatory Endoscopy Center -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 (978) 840-6767

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:_____

Greater Boston Anesthesia Associates, PLLC

Providing Professional Anesthesia Services for patients of Central Massachusetts Ambulatory Endoscopy Center

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Greater Boston Anesthesia Associates, PLLC all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between Greater Boston Anesthesia Associates, PLLC and my insurance company. I authorize and direct the insurance company to pay all such benefits to Greater Boston Anesthesia Associates, PLLC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and Greater Boston Anesthesia Associates, PLLC

Authorization to Release Claims Information: I hereby authorize Greater Boston Anesthesia Associates, PLLC it employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize Greater Boston Anesthesia Associates, PLLC its employees and agents to act on my behalf in completing claims including any appeal process.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that Greater Boston Anesthesia Associates, PLLC is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate, or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

Signature of Patient/Authorized Guardian Signature **Date**

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at Central Massachusetts Ambulatory Endoscopy Center by Greater Boston Anesthesia Associates, PLLC. Greater Boston Anesthesia Associates, PLLC are independent healthcare providers and are not employees or agents of Greater Boston Anesthesia Associates, PLLC. Greater Boston Anesthesia Associates, PLLC contracts certified registered nurse anesthetists and Anesthesiologist as part of the anesthesia care team.

Anesthesia services will be billed separately from the services of **Central Massachusetts Ambulatory Endoscopy Center**

For billing questions or concerns, please call: 1-888-337-3509. Local number: 1-508-532-6660

In the event that Greater Boston Anesthesia Associates, PLLC is not a participating provider with your insurance plan, Greater Boston Anesthesia Associates, PLLC will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses due to Greater Boston Anesthesia Associates, PLLC out-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.

INFORMED CONSENT FOR ANESTHESIA SERVICES

Central Massachusetts Ambulatory Surgery Center

Patient Name: _____ **Date of Birth:** _____

I have a general understanding of the procedure to be performed by my physician. I understand anesthesia services are requested or needed for the procedure. I consent to the administration of anesthesia as required for the procedure. I understand and acknowledge that all forms of anesthesia involve some risks and side effects, and the anesthesia provider can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. I acknowledge that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and will avoid making decisions or taking on activities, which depend on full concentration or judgment during this period.

It has been explained to me all forms of anesthesia have some risks and side effects. Although rare, unexpected severe complications can occur. Possible anesthetic complications include but are not limited to, infection, bleeding, drug interactions, allergic reactions, dental damage, stroke, brain damage, heart attack, cardiac arrest or death. Complications may require hospitalization. I understand that these risks apply to all forms of anesthesia; additional or specific risks are identified below, as they apply to each type of anesthesia.

I understand the section below details the types of anesthesia to be used for my procedure. I understand the anesthetic technique is determined by many factors including my physical condition, the procedure performed, the physician preference, anesthesia provider care of plan or my own desires. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesia provider and physician.

General Anesthesia: a controlled, drug-induced state of unconsciousness, accompanied by partial or complete loss of protective reflexes Including an inability to independently maintain an airway and/or respond purposefully to physical stimulation or verbal command. May require a placement of breathing tube in the windpipe or another breathing device. Risks include, but limited to, mouth or throat pain, hoarseness, injury to mouth or teeth, awareness of intraoperative events, injury to blood vessels, aspiration and pneumonia.

Deep Sedation: a controlled, drug induced state of depressed consciousness from which the patent is not easily aroused, which may be accompanied by partial loss of protective reflexes, including the ability to maintain an open airway independently and/or respond purposefully to physical stimulation or verbal commands. Risks include, but not limited to, infection, mouth or throat pain, hoarseness, injury to mouth or teeth, aspiration, dizziness, nausea or vomiting can occur.

Monitored Anesthesia Care (MAC): Anesthesia providers are present and able to provide indicated care based on my response to the procedure. Medications utilized may be sedatives, narcotics, and/or anesthetics and the degree of sedation or anesthesia cannot be specified ahead of time.

I understand the possible risk and complications of the planned anesthesia care as they have been explained to me. I have had the opportunity to ask questions, and I understand what has been explained. I hereby consent to anesthetic(s) above and authorized the credentialed anesthesia providers of this facility to provide the outlined anesthesia plan. I further understand and certify for my own safety, I have a responsible adult to take me home after my procedure.

X _____ _____ _____

Patient Signature/Legal Guardian | Relationship | Date:

_____ _____

Signature of Anesthesiologist/Anesthetist | Date/Time

Central Massachusetts
Ambulatory Endoscopy Center

Pregnancy Patient Waiver of Pre-Procedure Testing

I, _____/_____ **(Patient Name/ Date of Birth)** have no reason to believe that I am pregnant. However, my physician and anesthesia provider highly recommend pre-procedure pregnancy testing in all pre-menopausal and peri-menopausal women who have a history of missed or irregular menstrual periods.

_____ I understand that the anesthesia drugs that I will receive during my endoscopic procedure may cause complications with a pregnancy, including, but not limited to birth defects in my unborn child if I'm pregnant.

_____ I understand that even if a pre-procedure pregnancy test is done, a negative result does not absolutely guarantee that I am not pregnant.

_____I understand that I have been given the opportunity to delay the proposed endoscopic procedure in order that I may obtain diagnostic pregnancy testing but have elected to proceed with the proposed procedure without undergoing such pregnancy testing.

_____ I understand that by signing this form, I am releasing Central MA Ambulatory Endoscopy Center (CMAEC), the physician(s), anesthesia provider(s), and their employees, agents and assigns, from any and all liability, resulting from my failure to obtain a pre-procedure pregnancy test and any resulting harm to myself and an unborn child because of a pregnancy, including, but limited to, wrongful birth, birth defects, and/or emotional distress.

_____ I confirm that I have had the opportunity to have all my questions asked and answered concerning the proposed procedure and proposed anesthetic and its potential effects on pregnancy.

_____ I confirm that I have elected to proceed with the proposed procedure.

X _____ _____

Patient or Legal Representative Date

_____ _____

Anesthesia Provider Date