



142 Route 35 Suite 101, Eatontown, N.J. 07724 Phone (732) 935-0031 Fax (732) 935-0032

DEAR PATIENT,

WE LOOK FORWARD TO THE OPPORTUNITY TO PROVIDE YOU WITH THE BEST POSSIBLE CARE DURING YOUR SHORT STAY AT OUR AMBULATORY SURGERY CENTER. PLEASE TAKE A MOMENT TO READ THE INFORMATION CONTAINED IN OUR WELCOME PACKET, WHICH SHOULD ANSWER SOME OF YOUR QUESTIONS, AS WELL AS VISIT OUR WEBSITE AT WWW.ADVANCEDENDOSCOPY.COM TO VIEW OUR FACILITY, STAFF & PHYSICIANS. ALL NECESSARY FORMS CAN BE DOWNLOADED AND PRINTED FROM OUR WEBSITE. ALL OTHER FORMS WILL BE SIGNED ELECTRONICALLY, AS WELL AS AVAILABLE AT THE CENTER.

- PATIENT FINANCIAL RESPONSIBILITY (*WILL BE SIGNED ELECTRONICALLY AT THE CENTER*)
- RESPONSIBLE ADULT COMPANION (RAC) (*WILL BE SIGNED ELECTRONICALLY AT THE CENTER*)
- NOTICE OF PRIVACY PRACTICES (**COPIES AVAILABLE AT CHECK-IN**)
- PATIENT BILL OF RIGHTS & RESPONSIBILITIES (**COPIES AVAILABLE AT CHECK-IN**)

PLEASE MAKE SURE YOU HAVE UPDATED YOUR PHYSICIAN'S OFFICE STAFF WITH ANY CHANGES IN YOUR CURRENT ADDRESS, PHONE NUMBERS (HOME/WORK/CELL) YOUR PRIMARY CARE PHYSICIAN AND INSURANCE INFORMATION.

YOU **MUST** HAVE A RIDE HOME AFTER YOUR PROCEDURE & SOMEONE WHO CAN STAY WITH YOU AT HOME. SHOULD YOUR MEANS OF TRANSPORTATION BE BY TAXI OR A FORM OF UBER/LYFT, ETC. YOU **MUST** STILL BE ACCCOMPANIED HOME BY AN ADULT COMPANION FROM THE CENTER. THE TAXI/UBER/LYFT DRIVER IS **NOT** CONSIDERED A RESPONSIBLE ADULT COMPANION.

YOU SHOULD RECEIVE A PHONE CALL 1-2 BUSINESS DAYS PRIOR TO YOUR SCHEDULED PROCEDURE FROM ONE OF OUR **PRE-OP CALL NURSES TO GIVE YOU YOUR ARRIVAL TIME**.

IF YOU HAVE NOT HEARD FROM THE CENTER BY **3PM THE BUSINESS DAY PRIOR TO YOUR PROCEDURE** TO CONFIRM YOUR APPOINTMENT, PLEASE CALL THE CENTER IMMEDIATELY AT (732) 935-0031 PRIOR TO 4PM.

FEDERAL LAW REQUIRES THAT A CURRENT INSURANCE CARD AND PHOTO ID ARE PROVIDED ON THE DAY OF YOUR PROCEDURE. YOUR PROCEDURE MAY BE CANCELLED IF THE REQUIRED IDENTIFICATION IS NOT PROVIDED. COPIES FROM YOUR PHYSICIAN'S OFFICE ARE NOT ACCEPTABLE.

PLEASE BE SURE TO CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS, CO-PAYS AND DEDUCTIBLES ARE A REQUIRED FINANCIAL RESPONSIBILITY OF THE PATIENT. YOU WILL RECEIVE A PHONE CALL FROM OUR INSURANCE VERIFICATION DEPARTMENT TO VERIFY YOUR CO-PAY AND DEDUCTIBLE AMOUNTS THAT YOU **MUST** BRING WITH YOU ON THE DAY OF YOUR PROCEDURE OR SURGERY. **OUR VERIFICATION DEPARTMENT CAN BE REACHED AT 732-953-0031 BETWEEN 8A-4P M-F.**

IF YOUR INSURANCE PLAN REQUIRES YOU TO HAVE A REFERRAL FOR THE CENTER, YOU ARE RESPONSIBLE TO BRING ONE WITH YOU.

YOUR INSURANCE CARRIER MAY RECEIVE AS MANY AS FOUR (4) BILLS FOR YOUR STAY WITH US. THEY WILL BE BILLED FOR YOUR PHYSICIAN'S SERVICES, ANESTHESIA SERVICES, OUR SERVICES (FACILITY FEE) AND IN SOME CASES, LABORATORY SERVICES. YOU MAY BE RESPONSIBLE FOR A PORTION OF THESE CHARGES, EITHER A CO-PAY OR DEDUCTIBLE, AS DIRECTED BY YOUR INSURANCE CARRIER. **IF YOU HAVE QUESTIONS AFTER YOU RECEIVE YOUR STATEMENT, PLEASE CONTACT ADVANCED MEDICINE PRACTICE MANAGEMENT AT 866-516-2676 EXT 122 REGARDING YOUR FACILITY STATEMENT AND THEY WILL BE HAPPY TO GO OVER YOUR STATEMENT WITH YOU.**

ATTACHED YOU WILL FIND THE NAMES OF THE PARTICIPATING INSURANCE CARRIERS, PHYSICIANS, INCLUDING ANESTHESIA AND LABORATORIES USED.

THE GOAL OF OUR STAFF IS TO PROVIDE YOU WITH QUALITY CARE, AND MAKE SURE YOUR STAY WITH US IS CONVENIENT AND PLEASANT.

SINCERELY,

FRANCESCO G. RUSSO, MBA
CENTER ADMINISTRATOR



ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

142 Route 35 Suite 101, Eatontown, N.J. 07724 (732) 935-0031 Fax (732) 935-0032

PATIENT INFORMATION

Name: SS# Birth Date: / / Age: / /
Sex: [] Male [] Female Marital Status: [] Single [] Married [] Widowed [] Divorced
Phone: () Work Phone: () Cell: ()

Address: Street City State Zip
Patient's Employer: Occupation:

Employer's Address: Street City State Zip
Emergency Contact: Name Phone Relationship

PLEASE BRING YOUR INSURANCE CARDS TO THE CENTER ON THE DAY OF YOUR PROCEDURE

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER: DATE OF BIRTH:

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf, or to ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC., for any services furnished to me by that third party who accepts assignment/Physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature of Patient or Responsible Party

Date

I authorize Advanced Endoscopy & Surgical Center, LLC, to have access to my medical records concerning this date of service, and all prior and post medical records relevant to this date of service.

Signature of Patient or Responsibility Party

Date

LABORATORY TESTING

During the course of your procedure it may be necessary for your Physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New Jersey now requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Advanced Endoscopy & Surgical Center, to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing for the services will go directly to you as the patient.

Please complete and sign below so that we may direct this issue in the proper manner.

Thank you for your cooperation with this matter.

[] Yes, I am giving the laboratory permission to bill my insurance company.

[] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for the payment of services directly to the laboratory.

Signature of Responsible Party

Date

PATIENT LABEL



Preparing for Your Procedure Responsible Adult Companion Policy

Prior to your scheduled procedure your physician will provide you with specific instructions on how to prepare for your upcoming procedure. If you have any questions concerning this preparation, please call your doctor's office. Please arrive on time. Your procedure and subsequent recovery time takes approximately 2 to 3 hours from the time of your arrival to discharge. Our staff will do everything to make your stay as short as possible.

Due to the sedation you will receive prior to your procedure, you will not be permitted to drive yourself home, and you must make plans for someone to accompany you home from the Surgery Center. You will be discharged by the center into the care of your responsible adult companion, (your adult companion must be 18 years or older,) who will have the responsibility to drive you to your home and be available to make sure you have no adverse effects from the anesthesia.

INSTRUCTIONS FOR TRANSPORTATION

On the day of your procedure, a responsible adult companion must be able to drive you home. The responsible adult companion must agree to be with you, and be available to observe that you do not have any adverse effects from the anesthesia. It is recommended that your responsible adult stay with you 12 to 24 hours post procedure. If there is no responsible adult companion to accompany you from the Center, the procedure will be cancelled and must be rescheduled.

PATIENT

I acknowledge that I was informed at the time my procedure was scheduled that I must have a responsible adult companion accompany me from the Surgery Center, and be available to observe me for 6 to 8 hours after my procedure.

The name of my responsible adult is _____ and he/she will be available to bring me home immediately at the time of discharge. If he/she needs to leave the Center while I am undergoing my procedure, they must leave a contact phone number for the Nurse to call them when I am ready for discharge. Their cell number is: _____

I understand that if I do not have a responsible adult companion to take me home, my procedure will be cancelled.

Patient Signature

Date

Print Name

(Revised 11/2016)



OUT-OF-NETWORK COMMERCIAL INSURANCE AND SELF-PAY PATIENTS:

Advanced Endoscopy & Surgical Center, LLC. (AES) will bill your primary and secondary insurance carrier for the services you receive at our Center, in accordance with all applicable laws, rules regarding patient privacy, and security to ensure the confidentiality and safety of our patient's medical records. If AESC is out of network with your carrier, and you do not have secondary coverage with any other carrier and/or Medicare or Medicaid you will be financial responsible for all balances after your insurance carrier(s) has paid.

IN-NETWORK COMMERCIAL INSURANCE:

Please be advised that we participate with Aetna, Amerigroup, Amerihealth, ALL Blue Cross Blue Shield Plans, Cigna, Clover Health, New Jersey Carpenters, NJ Horizon Health, Magnacare, Qualcare, Tri-Care (Humana), Medicaid, Medicare, Railroad Medicare, United/Oxford, US Family Plan and Well Care. You will be billed according to your plan's benefit allowances, i.e. co-insurance/co-pay and or deductible applied. If your insurance policy is a Medicare replacement plan, it is subjected to Medicare guidelines and allowable rates. You will be responsible, and billed for any and all co-insurance/co-pay or deductible applied.

You may also receive a bill from **AESC** for the **FACILITY FEE** if:

- 1) The coverage is not actually current or payment is denied by your carrier due to pre-existing conditions.
- 2) You do not provide information requested by your insurance carrier after they receive our bill.
- 3) Your policy benefits have been exhausted (i.e. you've reached your benefit maximum).
- 4) Your insurance carrier mailed payment to you rather than AESC, and you did not forward the payment as instructed below.
- 5) We've had no response from your insurance carrier with no resolution.

IN-NETWORK PATIENT RESPONSIBILITY FINANCIAL POLICY:

Please be advised that upon receipt of payment from all of your insurance plans, you will be balanced billed for any additional patient responsibility, co-insurance/co-pay and/ or deductible that was not received at the time the service was rendered. Thirty (30) days after the initial bill has been sent to you, we will make one collection phone call to you, the patient. Next a collection letter will be sent advising that we need a response/contact to discuss the bill for payment arrangements. If we have no response to our attempt in contacting you within 14 days from the date of the letter your account balance will be sent out for OUTSIDE COLLECTION ACTIVITY, and you will be responsible for the balance, along with 30% collection fees added to the bill. You will also be responsible for any and all additional collection fees including court costs, and attorney fees incurred as a result of this debt.

AESC does not participate with all commercial insurance carriers. Payment may be made directly to the patient for the facility fee. **PLEASE DO NOT DEPOSIT THE CHECK**. Endorse the check and forward it with the accompanying explanation of benefits to the address listed above, to the attention of the Billing Office. We will receive confirmation from your insurance that they have forwarded the payment to you. If you do not turn over the check and the explanation of benefits to AESC you will be responsible for the bill IN FULL, plus any additional court fees or attorney's fees incurred in the collection of your account.

ANESTHESIA CHARGES: When procedures are performed at AESC, anesthesia services are provided, and will be billed to your insurance carrier. In the event you receive the payment from the insurance carrier, **DO NOT DEPOSIT THE CHECK**. Please endorse the check on the back & forward the check with the explanation of benefits to the Physician who performed your procedure at their office.

LABORATORY CHARGES: Laboratory services are billed separately through ADH-Pathology Lab, Dianon, ENDO-CDX and Genesis Laboratory.

I have read and understand the above information. I agree to the terms and conditions as noted above:

Patient Signature

Date

Advanced Endoscopy & Surgical Center, LLC.

142 Route 35, Suite 101 Eatontown, New Jersey 07724

Tel: (732) 935-0031 Fax: (732) 935-0032

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information:

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures, will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

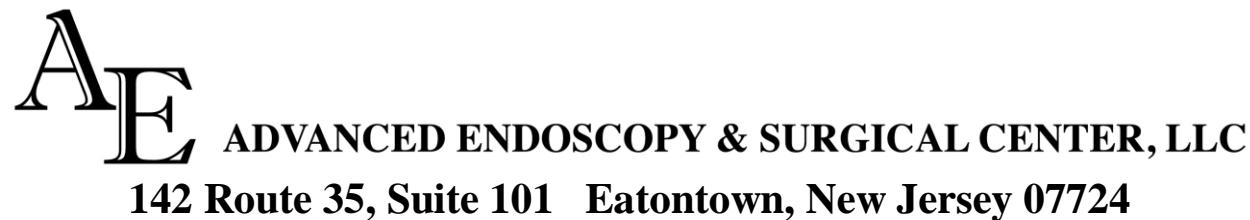
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact Francesco Russo, Administrator or Tara Delnero, Director of Nursing at (732) 935-0031. **We will not retaliate against you for filing a complaint.**



Is Proudly Owned and Operated by:

Jersey ASC Ventures, LLC. and the Physicians of AESC:

Eric Abrams, D.P.M.

Kenneth Belitsis, M.D.

Thomas Fiest, D.O.

Howard Guss, D.O.

Andrew Kruger, D.O.

Evan Orosz, D.O.

Sandhya Shukla, M.D.

Nadeem Baig, M.D.

Gagan Beri, M.D.

Steven Gorcey, M.D.

Kenny Hui, M.D.

Lawrence Menditto, D.P.M

Scott Schlachter, D.O.

Matthew Tangorra, D.O.

William Basri, M.D.

Mark Cerefice, M.D.

Thaddeus Grabowy, M.D.

Kaswala, Inc.

Laleh Merikhi, M.D.

Shefalie Shah, M.D.

Vinay Yalamanchi, D.O.

According to the State of New Jersey Senate No. 787, under the Codey Law, “practitioners are permitted to refer patients to certain surgical practices, and ambulatory care facilities in which they have a financial interest. The practitioner shall provide the patient with a written disclosure form stating their ownership, in addition to informing the patient whether the services provided at the practitioner’s licensed ambulatory surgical facility, and reimbursed at, an “out-of-pocket” level by the patient’s insurance carrier or other third-party payer.”

Please take notice that your practitioner listed above has a financial interest in the following healthcare service(s) to which patients are referred to:

Advanced Endoscopy & Surgical Center, LLC.

You may of course, seek treatment at a healthcare service provider of your choice. A listing of alternative healthcare service providers can be found in the classified section of your telephone directory under the appropriate heading.



The Patient's Bill of Rights & Responsibilities, Including Notification of Physician Ownership



Every patient has the right to be treated as an individual and to actively participate in and make informed decisions regarding his/her care. Advanced Endoscopy & Surgical Center, LLC and the Medical Staff have adopted the following patient rights and responsibilities, which are communicated to each patient or the patient's representative/surrogate prior to the procedure/surgery.

PATIENT'S BILL OF RIGHTS:

Every patient has the right to be treated as an individual with his/her RIGHTS respected. Advanced Endoscopy & Surgical Center, LLC. and Medical Staff have adopted the following list of patient's rights:

PATIENT'S RIGHTS:**PATIENT'S RIGHTS: NJAC 8:43A-16.2**

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. To be informed if Advanced Endoscopy & Surgical Center, LLC. has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
9. To confidential treatment of information about the patient.
 - a. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the Department for statutorily-authorized purposes.
 - b. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;
12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient;
13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility; and
14. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43E-6.

PATIENT RIGHTS: AAAHC

1. To be treated with respect, consideration, and dignity.
2. To be provided with personal privacy.
3. To receive care in a safe setting.
4. To be free from all forms of abuse or harassment.
5. To be free from any act of discrimination or reprisal.
6. To voice grievances regarding treatment or care that is (or fails to be) furnished.
7. To be fully informed about a treatment or procedure and the expected outcome before it is performed.
8. To be provided information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
9. To be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
10. If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
11. To be informed of their right to change providers if other qualified providers are available.

PATIENT RESPONSIBILITIES

1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
1. Follow the treatment plan prescribed by his/her provider and participate in his/her care.
2. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
3. Accept personal financial responsibility for any charges not covered by his/her insurance.
4. Be respectful of all the health care professionals and staff, as well as other patients.

Please note:

- If you believe the care provided to you in a hospital by a doctor was improper, you may file a [complaint](#) with the Board of Medical Examiners. However, Because the regulation of hospitals is under the jurisdiction of the New Jersey Department of Health and Senior Services (DHSS), if you believe you received improper care at a hospital, you should contact the DHSS Complaint section at (800) 792-9770.

If you need an interpreter:

If you need an interpreter, **please let us know before your procedure**, and one will be provided for you.

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

Statement of Nondiscrimination:

Advanced Endoscopy & Surgical Center, LLC. complies with applicable Federal civil rights laws and does not discriminate on the basis of: race, color, national origin, age, disability, or sex.

Advanced Endoscopy & Surgical Center, LLC. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Advanced Endoscopy & Surgical Center, LLC. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in New Jersey Statutes § 26:2H-53 through 78. In the state of New Jersey, all patients have the right to decide what medical treatment they want or do not want to receive. They can decide in advance what treatment they would want, and put that decision in writing, or they may name someone else who understands and shares their values, to exercise that right for them. Under New Jersey Law, there are three kinds of Advance Directives: Proxy, Instruction Directive ("Living Will") or Combined Directive. http://www.state.nj.us/health/advancedirective/documents/njsa_26.2h.53.pdf

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

Advanced Endoscopy & Surgical Center, LLC. respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances:

If you believe the care provided to you this surgery center and or by a physician was improper, you may file a complaint with the Board of Medical Examiners.

However, because the regulation of hospitals is under the jurisdiction of the New Jersey Department of Health and Senior Services (DHSS), if you believe you received improper care at this surgery center, you should contact the DHSS Complaint section at (800) 792-9770.

You may also complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may also file a complaint with us by notifying our privacy contacts: Francesco Russo, Administrator and/ or Tara Delnero, Director of Nursing at (732) 935-0031. WE will not retaliate against you for filing a complaint.

State Website: <http://www.state.nj.us/lps/ca/bme/bmeform.htm>

Medicare beneficiaries may also file a complaint with the Office of Medicare Beneficiary Ombudsman. **Medicare Ombudsman Web site:** <https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home>

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

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

Advanced Endoscopy & Surgical Center, LLC. is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:

AAAHC

3 Parkway North Blvd, Ste 201

Deerfield, IL 60015

Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

Physician Financial Interest and Ownership: **Physician Financial Interest and Ownership:** The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: See Attached

Advanced Endoscopy & Surgical Center, LLC.
142 Route 35 South, Eatontown, NJ 07725
(732) 935-0031

Label for Medical Records