Woodbridge
Internal Medical Associates

1000 Route 9 North, Suite 302, Woodbridge, New Jersey 07095
732/634-0036 Fax 732/634-9182 www.woodbridgemed.com

Gastroenterology
Seth M. Webber, M.D.
Internal Medicine
Mary T. O'Donnell, M.D.
Lauren Maza, M.D.
Louis Friedman, D.O.

Gastroenterology Procedures Consent Form

You have been or will be scheduled for a Gastroenterology Procedure with Dr. Seth Webber. Please be aware that Woodbridge Internal Medical Associates, PA will call your insurance company to verify your benefits. This is not a guarantee of coverage or payment or does it mean that your procedure will be 100% covered with no out of pockets costs to you. For that reason, we ask that you, the patient, also call your insurance company before your scheduled procedure to verify Both Professional and Facility benefits for any deductibles or co-insurance for which you may be responsible.

If you have a deductible that has not been met, Woodbridge Internal Medical Associates, PA will require a payment of $150 by cash or credit card, prior to your procedure, unless the amount owed is less. ($80 for EGD Only)

If the balance of your deductible is over $130 the following payment options are available in order to satisfy the balance of patient responsibilities:

1. Cash, check, or credit card to satisfy the balance in full.
2. Three (3) month repayment plans are offered. Please contact our billing office to set up this payment arrangement at (732) 634-0036 option #5.

The following are procedure codes to be used when verifying coverage with your insurance:

- **Colonoscopy CPT Code: 45380**
  ($150 is required if deductible has not been met)
- **EGD-Upper Endoscopy CPT Code: 43239**
  ($80 is required if deductible has not been met)

If both procedures are medical and being performed together on the same day, we will require the following payment: **Colonoscopy $150.00 + EGD $80.00 for a total of $230.00**

Woodbridge Medical Associates, PA will not be responsible for incorrect benefits quoted to us by your insurance plan.

PLEASE NOTE: If, during a screening colonoscopy you are found to have an area that requires a biopsy to be taken and pathology is sent out, your screening is now a diagnostic colonoscopy. This may change your responsibility in reference to coverage and deductible responsibility.

Patient Name (please print): _____ D.O.B ____/____/____

Patient Signature: _____ Date: ____/____/____

Witness: _____ Insurance Plan: _____

MAY STREET SURGI CENTER
FINANCIAL CONSENT FORM

You have been or will be scheduled for a Gastroenterology Procedure with Dr. Seth Webber. Please be aware that Woodbridge Internal Medical Associates, PA will call your insurance company to verify your benefits. This is not a guarantee of coverage or payment or does it mean that your procedure will be 100% covered with no out of pockets costs to you. For that reason, we ask that you, the patient, also call your insurance company before your scheduled procedure to verify Both Professional and Outpatient Facility benefits for any deductibles or co-insurance for which you may be responsible.

If you have a deductible that has not been met, we will require a payment on the day of your procedure based on the real-time information from your insurance carrier. If you have a co-pay, you will be required to pay that amount, in full, on the day of your procedure. Someone will call to inform you of your paymen expectation prior to the procedure of any unsatisfied deductible. If you are unable to pay the expected amount in full, your payment options will be discussed with you at that time.

Cash, check, or credit card are accepted forms of payment to satisfy the balances in full or the agreed upon required payment by you and the billing department.

Please inform our office if you have an HSA (Health Savings Account) or a FSA (Flexible Spending Account). You will be expected to pay your anticipated out of pocket expense on the day of your procedure with that card. _____ HSA _____ FSA

Three (3) and six (6) month repayment plans are offered through InstaMed. The remaining unpaid balance of any deductible and/or coinsurance is divided into three of six equal payments that will be automatically drafted from your bank account or credit card on the same date each month. You may choose to set up the payment plan after receiving your bill. The can be done by going to the website: https://pay.instamed.com/default.aspx?id=MSSC and selecting the "Create a Payment Plan" option after entering the required patient detail information.

The following are procedure codes to be used when verifying coverage with your insurance:

- **Colonoscopy CPT Code: 45380**
- **EGD-Upper Endoscopy CPT Code: 43239**

Woodbridge Medical Associates, PA will not be responsible for incorrect benefits quoted to us by your insurance plan.

IF YOU HAVE ANY SIGNS OR SYMPTOMS (EXAMPLES INCLUDE: ABDOMINAL PAIN OR RECTAL BLEEDING) OR IF YOU HAVE A PERSONAL HISTORY OF POLYPS, SCREENING BENEFITS WILL NOT APPLY.

Patient Name (please print): _____ D.O.B ____/____/____

Patient Signature: _____ Date: ____/____/____

Insurance Plan: _____

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Disclosure of Ownership

To Our Patients:

"Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform patients of any significant financial interest he may have in health care service."

Accordingly, we wish to inform you that Dr. Seth Webber has a financial interest in the May Street Surgi Center, LLC.

Dr. Webber became an owner as a result of his commitment to quality health care and to provide better service to his patients. The May Street Surgi Center, LLC is fully accredited by the Center for Medicare and Medicaid Services (CMS).

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

I have read the above and understand.

Patient Name (please print): _____ D.O.B ____/____/____

Patient Signature: _____ Date: ____/____/____

MAY STREET SURGI CENTER

205 MAY STREET SUITE 103

EDISON, NJ 08837

732 661 9075

WELCOME TO MAY STREET SURGI CENTER

Attached is Patient information regarding your upcoming Procedure at the May Street Surgi Center. Please review all the Documents as they pertain to your health and well-being while at the facility.

Your only responsibility is to:

1. Fill out the pre procedure interview/ past Medical History forms and Bring it with you
2. Read and sign the OON disclosure form
3. You must have a form of Identification; Example **Driver's License**
4. Bring your **Insurance Card** and a copy of **referral** if indicated by your plan
5. Leave all jewelry and valuables at home (you will be requested to remove all jewelry and body piercings) the center is not responsible for lost or misplaced items.
6. You will receive a phone call to confirm your appointment 1-2 days prior to the scheduled date if you have questions or concerns please contact us.

We want to ensure you are informed of your entire Patients' Rights, Financial expectations and what to expect on the day of the procedure please read all the forms in this Packet. You may receive a survey after your visit; we would appreciate the time you take to provide us with any feedback.

Thank you

PLEASE COMPLETE THIS FORM – BRING ON DAY OF PROCEDURE

Patient's Name: _____

Pre Procedure Interview / Past Medical History

Heart Disease	Hypertension	Diabetes	Kidney Disease
Heart Attack	High Cholesterol	Neurology Disease	Sleep Apnea
Heart Murmur	Lung Problems	CVA / Stroke	Seizures
Valve Replacement	Asthma	Thyroid Disease	Hepatitis
Cardiac Stent	Emphysema	Tuberculosis	HIV / AIDS
Pace Maker			

History of mental illness:_____

Cancer: _____ Received Chemotherapy / Radiation: _____

Recent Hospitalizations: _____

GI Disease _____ Have You ever had a Colonoscopy? Yes__No__ EGD? Yes__No__

Findings_____

Height_____ **Weight**_____

Last Menstrual Period: _____

Women may need to provide a urine Sample before your Procedure

Smoke: No/ Yes /How Much ___ How Long____ Alcohol Intake Daily: Yes /No

Recreational Drug Use: _____

Previous Surgeries: _____

Allergy to Food & Medication: _____

Type of Reactions_____

Allergy to Latex: Yes_____ No _____

Please List All Medications Prescribed & Over the Counter / Vitamins

IF *you are currently using an Inhaler You Must bring it with you*

Medication List: Dosage: Frequency: Last Dose:

_____

_____

_____

_____

_____

For additional medications please use reverse side.

Bring your ID& Insurance Cards with this completed form.

- Do not bring any valuables (Jewelry and All Body Piercing MUST BE REMOVED).
- Someone must be available to drive you home. ***You cannot drive after the procedure.***
- Follow your doctor's instructions for the procedure; especially if there are certain medicine they instruct you to take
- No eating or drinking for at least 6 hours before the exam.

MAY STREET SURGI CENTER IN-NETWORK POLICY

- *May Street Surgi Center is in network with your insurance plan*
- *Because May Street Surgi Center is in network, you will not pay more than your in-network copayment, coinsurance or deductible for the hospital's services.*
- *If May Street Surgi Center's network status changes with your health insurance plan prior to your scheduled appointment, May Street Surgi Center will notify you.*
- *Prior to receiving services, it is important that you contact your insurance company to determine your potential out-of-pocket costs under your insurance plan and to double-check that your individual healthcare services are covered and authorized.*
- *Not all of the physicians who perform procedures at May Street Surgi Center participate in the same health insurance plans that May Street Surgi Center accepts.*
- *You should check with the physician who ordered the healthcare services and ask whether the physician is in network or out of network with your health insurance plan. You should also ask if there are additional physicians who may be involved with your care.*
- *We have a list of all contracted physicians who practice at May Street Surgi Center on our website. You may contact the physicians directly to see if they participate in your health insurance plan.*
- *The physicians bill separately. So, you may receive more than one bill for your healthcare services.*
- *If a physician is in network, you should never be charged more than your in-network copayment, coinsurance or deductible.*
- *If an in-network provider charges more than your in-network copayment, coinsurance or deductible, you should notify your health insurance plan and the Department of Banking and Insurance/Department of Health.*

Additional Disclosures – Self-Funded Plans

- *If you have a health insurance plan that is self-funded, it's important to know these insurance plans are not required to follow the "Out-of-Network" law.*
- *We must advise you that any services you receive at May Street Surgi Center may be out-of-network with your health insurance plan.*
- *Because of this, you may pay more than your co-payment, coinsurance or deductible for services received or performed at this facility.*
- *You may also have to pay the balance above any amount that your insurance plan paid for the services.*

*Signature:*_____ *Date:*_____

MAY STREET SURGI CENTER – OUT-OF-NETWORK POLICY

- *May Street Surgi Center is out-of-network with your insurance.*
- *Prior to receiving services, it is important that you contact your insurance company to determine your potential out-of-pocket costs under your insurance plan and to double-check that your individual healthcare services are covered and authorized.*
- *Because May Street Surgi Center is out of network, you may pay more than your in-network co-payment, coinsurance or deductible for the services received or performed at this facility.*
- *You may be responsible for any difference between what your insurance company pays May Street Surgi Center for the service and what May Street Surgi Center charges.*
- *If you wish to receive services at May Street Surgi Center, first please contact your insurance company to determine if you have an out-of-network benefit option. If you do, you should ask what your potential out-of-pocket costs may be and double-check that your services will be covered. If you do not have an out-of-network benefit option, you will be responsible for all charges.*
- *You should check with the physician who ordered the healthcare services and ask whether the physician is in network or out of network with your health insurance plan. You should also ask if there are additional physicians who may be involved with your care.*
- *Not all of the physicians who perform procedures at May Street Surgi Center participate in the same health insurance plans that May Street Surgi Center accepts.*
- *We have a list of all contracted physicians who practice at May Street Surgi Center on our website. You may contact the physicians directly to see if they participate in your health insurance plan.*
- *The physicians bill separately. So, you may receive more than one bill for your healthcare services.*
- *If a physician is in network, you should never be charged more than your in-network copayment, coinsurance or deductible.*
- *If an in-network provider charges more than your in-network copayment, coinsurance or deductible, you should notify your health insurance plan and the Department of Banking and Insurance/Department of Health.*

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- *Because of this, you may pay more than your co-payment, coinsurance or deductible for services received or performed at this facility.*
- *You may also have to pay the balance above any amount that your insurance plan paid for the services.*
- *If you wish to receive services at May Street Surgi Center, please contact your insurance plan to find out if you have an out-of-network benefit option. If you do have an out-of-network benefit option, you should inquire about your potential out-of-pocket costs and double-check that the healthcare services will be covered. If you do not have an out-of-network benefit option, you will be responsible for all charges.*

Signature:_____ Date:_____

THE 6 STEPS OF YOUR VISIT TODAY

If you have questions at anytime during your visit please find the nearest staff member to help you

Step 1: Register with Receptionist
- Copy of your insurance card
- Sign Consent Form
- Fill out Medical Consent Form*

Step 2: Pre-admission
- Leave personal belongings with family member /friend
- **You may need to leave a urine sample so please ask before using the bathroom ONLY WOMEN OF CHILD BEARING YEARS**
- Change your clothes
- Basic tests and medical history are taken to make sure okay
- Nurse will confirm your procedure and doctor (this is asked several times for your safety)
- Will start an IV
- Ask any questions or concerns you may have
- You will meeting the anesthesiologist and procedure nurse – please ask any sedative questions you may have

Step 3: Proceed to Procedure Room
- Meet your doctor and the nurse staff member who will help with procedure
- You will be rolled onto your left side for procedure
- They will start the anesthesia in your IV
- The colonoscopy will be performed takes about 20 minutes
- The EGD will take approx 15minutes

Step 4: Recovery Room
- Moved to recovery room where it will take about 30 minutes to wake
- Your doctor will talk to your family and you about the findings. If your family needs to be called they will call your family at this time.
- When you are awake you will be given a drink and a light snack.
- Your doctor will talk to you about what he/she saw in the procedure and any instructions for you

Step 5: After Recovery Room
- You will be assisted in getting dressed and/or go to bathroom
- You will relax in recliner as you wait for your ride
- Then you will be discharged to a responsible adult and walked to the car

Step 6: Post Procedure
- Resume your normal diet and medications
- If any instructions vary for you they will be given to you in writing so you remember
- We will call you the day after your procedure to see how you are doing

It is important that you **DO NOT** drink alcoholic beverages for 24 hours
It is important that you **DO NOT** drive for 24 hours
It is important that you follow up with your doctor in his/her office
****PLEASE CALL IMMEDIATELY IF YOU HAVE ANY PAIN, BLEEDING, NAUSEA, VOMITING OR FEVER – 24 hours/day, every day 732-661-9075**

*if applicable

Authorization for and Consent to Procedure

I consent to allow my physician, _____, and such other assisting physicians and healthcare personnel as requested by my physician to perform the following procedure:

_____

My physician has explained to me the nature and purpose of the procedure that will be performed. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives to the procedure. The potential risks or complications of this procedure include infection, adverse reaction to medication, dental trauma, and injury to organs, bleeding, perforation, cardio/respiratory complications, and death that are attendant to the performance of any procedure. In a small percentage of patients, a failure of diagnosis or a miss-diagnosis may result. Other risks specific to this procedure may include:

_____

_____

I understand that there are risks with any procedure, and it is impossible for the physician to inform me of every possible complication.

I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction.

I understand that anesthesia services are being provided by anesthesia provider and I will sign a separate consent form for those services.

In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the surgeries or procedures to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, to be in attendance during my procedure if the situation arises.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the procedure.

I have been given the opportunity to ask questions about the procedure that will be performed. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives and I enter into this contract to consent to the procedure freely. _____ (initial)

The undersigned certifies that he/she has read the foregoing and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____ _____

Patient Signature Date/Time

_____ _____

Patient Representative Signature / Relationship Date/Time

_____ _____

Witness Signature Date/Time

Physician Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the procedure and have allowed the patient/responsible adult to ask questions.

_____ _____

Physician Signature Date/Time

Consent for Anesthesia Services

I authorize the Anesthesia Provider, _____, to provide anesthesia services as part of my upcoming surgery or procedure.

I understand and agree that the primary method of anesthesia administration will be Deep Sedation. This method has been discussed with me in terms that I can understand. If, in the course of treatment, conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it. These may include, but are not limited to: swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma, including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings, and laceration of the gums or lips; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulties breathing, permanent organ damage, cardiac arrest and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I have been given the opportunity to ask questions about the anesthesia. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any procedure and anesthesia, and it is impossible for the physician to inform me of every possible complication. I believe that I have sufficient information to give this informed consent.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____ _____

Patient Signature Date/Time

Anesthesia Provider Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/responsible adult to ask questions.

_____ _____

Anesthesiologist Signature or
Certified Registered Nurse Anesthetist Signature

Date/Time

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information

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

How We Use & Disclose Your Patient Health Information

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

Special Uses and Disclosures

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

Other Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law Enforcement Purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

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

Individual Rights

You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

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

Our Legal Duty

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

Changes in Privacy Practices

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

Complaints

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

Contact Person

If you have any questions, requests, or complaints, please contact: Center Leader

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

Signed: _____ Date: _____

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

Staff Witness seeking acknowledgement: _____ Date: _____

FORM-MULTIPLE AUTHORIZATION

May Street Surgi Center

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. Should my account with May Street Surgi Center be referred to an attorney or outside agency for collection, I understand that I am financially responsible for any balance for collection: a collection fee of 25% of the balance owed will be added to the balance.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to May Street Surgi Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at May Street Surgi Center may have an ownership interest in May Street Surgi Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at May Street Surgi Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have offered / received written and verbal notification regarding my Patient Bill of Rights prior to my procedure. I have also received information regarding May Street Surgi Center policies pertaining to ADVANCED DIRECTIVES / POLST prior to the date of the procedure. Copies of Advanced Directives and POLST information were made available to me.
I have been advised to keep all valuables & jewelry home and not bring them to the center , or have a family member safe guard them for me while I am at the facility as May Street is not responsible for any lost or broken items.

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

_____ _____

Signature of Patient or Responsible Party Print Name

_____ _____

Relationship to Patient Date Signed

AVISO DE PRÁCTICAS DE PRIVACIDAD

Este Aviso describe cómo puede usarse y revelarse su información médica y cómo puede usted tener acceso a ella. Estúdielo con cuidado.

Información médica del praciente

De acuerdo con las leyes federales, su información médica está protegida y es confidencial. La información médica del paciente incluye información sobre sus sintomas, resultados de análisis, diagnósticos, tratamiento y otra información médica relacionada. Su información médica incluye también información sobre pagos, facturación y seguros. Es possible que su información se guarde electrónicamente y, de ser asi, estará sujeta a la divulgación electrónica.

Como usamos y revelamos su informacion medica del paciente

Tratamiente: Usaremos y revelareomos su información médica para suministrarle tratamiento o servicios médicos. Por ejemplo, enfermeros, médicos y otros integrantes de su equipo de tratamiento registrarán información en su historia clinica y la usarán para determiner las opciones de atención más apropiadas. También podremos reveler la información a otros proveedores de atención médica que participen en su tratamiento, a farmacéuticos que provean sus medicamentos recetados y a familiars que ayuden con su atención.

Pagos: Usaremos y revelaremos su información médica para obtener pagos. Por ejemplo, es possible que debamos obtener autorización de su compañia de seguros antes de brindar ciertos tipos de tratamiento o reveler su información a pagadores para determiner si esta inscrito o si es eligible para recibir los beneficios. Entregaremos factures y conservaremos registros de pagos de su plan de salud.

Operaciones de atención de la salud: Usaremos y revelaremos su información médica para llevar a cabo nuestras operaciones internas habituales, que incluyen la administración adecuada de los registros, la evaluación de la calidad del tratamiento, la coordinación de servicios legales, y evaluar la atención y los resultados de su caso y de otros como el suyo.

Divulgaciones y usos especiales

Luego de un procedimiento, revelaremos sus instrucciones de alta e información relacionada con sum atención, a la persona que to llevará hasta su case desde el centro o que, de otro modo, esté identificada como la persona que le ayudará en su atención posterior al procedimiento. Es possible qu también revelemos información médica relevante a un familiar, amigo u otra persona que esté involucrada en su atención o el pado de su atención, y que revelemos información a aquelias personas que brinden asistencia en actividades de auxilio en caso de catástrofes.

Otros usos y divulgaciones

Es possible que debamos o que se nos permita usar o reveler la información incluso sin su permiso, según se describe a continuación:

Cuando está exigido por ley: Probablemente nos veamos obligados por ejemplo por ley a reveler información, como por ejemplo informar heridas de bala, sospechas de abuso o negligencia, o lesions y eventos semejantes.

Fines de investigación: Podemos usar o reveler información para investigaciones medicas autorizadas.

Actividades de salud pública: Podemos reveler a las autoridades sanitarias estadisticas vitals, enfermedades, información relacionada con el retiro de productos peligrosos del mercado y otros datos similares.

Supervision de la salud: Es possible que revelemos información con el fin de ayudar en investigaciones y auditorias, determiner la elegibilidad para programas gubernamentales y actividades similares.

Procedimientos judiciales y administrativos: Podemos reveler información en respuesta a un emplazamiento, una solicitud de divulgación o una orden de un tribunal apropiado.

Fines relatives a la observacia de las leyes: Es possible que revelemos información que funcionarios a cargo del cumplimiento de las leyes necesiten o soliciten o que denunciemos un delito en nuestras instalaciones.

Muertes: Podemos reveler información acerca de muertes a médicos forenses, peritos médicos, directores de casas funerarias y agencias de donación de órganos.

Amenazas serias a la solud o a la seguridad: Podemos utilizar y reveler información cuando sea necesario para prevenir una amenaza seria a sum salud o seguridad, o a la salud y seguridad del public o de un tercero.

Funciones militores o especiales del gobierno: Si usted es un integrante de las fuerzas armadas, podemos entregar información requerida por las autoridades del commando militar. También podemos reveler información a instituciones correccionales o con fines de seguridad nacional.

Compensación a trabajadores: Podemos reveler información sobre usted a programas de compensación a trabajadores o similares que otorguen benficios por lesions o enfermedades relacionadas con el trabajo.

Asociados comerciales: Podemos reveler su información medica a asociados comerciales (personas o entidades que desempenan funciones en nuestra representacion), siempre que acuerden proteger la informacion.

Mensajes: Podemos contactarnos con usted para enviarle recordatorios de citas, o para realizar facturaciones o cobros, y podemos dejar mensajes en su contestadora, correos de voz o utilizar otros métodos.

En cualquier otra situación, solicitaremos su autorización por escrito antes de usar o reveler información médica que los identifique. Si usted opta por firmar una autorización para reveler información, puede revocarla después para detener todo uso o divulgación futuros. Conforme al cumplimiento con excepciones limitadas, no utilizaremos ni revelaremos notas de psicoterapia, ni tampoco su infomación médica para fines de comercialización, ni venderemos su información médica, salvo que usted haya firmado una autorización.

Derechos individuals
Usted tiene los siguientes derechos relatives a su información médica. Comuniquese con la persona de contacto indicada más abajo para conocer la forma apropiada de ejercer estos derechos.

- Usted puede solicitor que se apliquen restricciones a ciertos usos y divulgaciones. No tenemos la obligación de aceptar una restricción solicitada, salvo las solicitudes de limitar las divulgaciones a su plan de salud para fines de operaciones de atención médica o pagos cuando haya padado en su totalidad con dinero propio el articulo o servicio cubieto por la solicitud, y cuando la ley no exija los usos o las divulgaciones.
- Usted puede solicitarnos que nos comuniquemos con usted de manera confidencial; por ejemplo, enviando los avisos a una dirección especial o no usando tarjetas postales para recordarle las citas.
- En la mayoria de los casos, usted tiéne derecho a ver u obtener una copia de su información médica. Es possible que se cobre un pequeño monto por las copias.
- Tiéne derecho a solicitar que corrijamos su información.
- Usted puede solicitor una lista de las divulgaciones de su información por razones que no se relacionen con tratamientos, pagos u operaciones de atención médica y salvo por otras excepciones.
- Usted tióne derecho a obtener a pedido una copia impresa de la versión vigente de este Aviso, aunque haya acordado previamente recibirlo por via electrónic.

Nuestras obligaciones legales
Las leyes nos obligan a proteger y mantener la privacidad de su información médica, a entregarle este Aviso sobre nuestras obligaciones legales y prácticas de privacidad con respect a la información médica protegida, y a cumplir los términus del Aviso actualmente vigente. Debemos notificar a las personas afectadas en caso de un incumplimiento que involucres información médica sin protección.

Cambios en las prácticas de privacidad
Es possible que cambiemos este Aviso en cualquier momento y que los nuevos términus entren en vigencia para toda la información médica que poseemos. Le fecha de vigencia de este Aviso se indica al final de la página. Si cambiamos nuestro Aviso, colocaremos el Nuevo document en la zona de espera. Para obtener más información acerca de nuestras prácticas de privacidad, comuniquese con la persona indicada más abajo.

Quejas
Si le preocupa que podamos haber violado sus derechos de privacidad, puede comunicarse con la persona indicada más abajo. También puede enviar una queja por escrito al Departamento de Salud y Servicios Humanos (Department of Health and Human Services) de los EE. UU. A su solicitud, la persona indicada más abajo le indicará cuál es la dirección adecuada para el envoi. Usted no sufrirá penalización alguna por presenter una queja.

Personal de contacto
Si tiene preguntas, solicitudes o quejas, comuniquese con:

Director del centro

Yo, _____, acuso recibo del Aviso de prácticas de privacidad que se me ha entregado.

Firma: _____ Fecha: _____

Si no se firma, razón por la cual no se obtuvo el acuse de recibo: _____

Testigo del personal qu solicita el acuse de recibo _____ Fecha: _____

Directions
May Street Surgi Center
EDISON OFFICE -205 MAY STREET, SUITE 103- EDISON, NEW JERSEY 08837

NJ TURNPIKE: Exit 10 – bear left to 287 North, Metuchen and Woodbridge, then bear right to ROUTE 514 EAST (Woodbridge-Fords). Turn right at first traffic light. This is May Street (St. Nicholas Church on your right). Make the first right; 205 May Street is on the right. Turn right into the parking lot.
ROUTE 287 SOUTH: Exit at ROUTE 514 EAST (Woodbridge-Fords). Make a right turn at second traffic light, intersection of Amboy & Woodbridge Avenue (Gas station on right). Follow Amboy Avenue, past Our Lady of Peace Church, to the next traffic light. Turn right on King Georges Post Road (Dunkin Donuts on the left). FOLLOW UNTIL THE THIRD RIGHT TURN (MAY STREET). FOLLOW MAY STREET PASSING THE PARK, MAKE 2ND LEFT TURN INTO THE COMPLEX AND PARK IN LOT ON RIGHT BEHIND 205 MAY STREET. (THE ONLY TWO STORY BUILDING).
GARDEN STATE PARKWAY NORTHBOUND: Exit 127 – Follow signs for Route 9 – New Brunswick Avenue Exit, turn right at end of exit. Continue straight to King Georges Post Road (traffic light and Dunkin Donuts will be on your left) and turn left. **FOLLOW DIRECTIONS AS ABOVE**.
GARDEN STATE PARKWAY SOUTHBOUND: Exit 129, bear right to first exit – Fords ROUTE 501. This exits to King Georges Post Road. Follow straight across intersection of New Brunswick Avenue and King Georges Post Road (Dunkin Donuts on the left). **FOLLOW DIRECTIONS AS ABOVE**.
ROUTE #1 SOUTHBOUND: Pass Menlo Mall and Roosevelt Park. The next exit is ROUTE 501 (Fords-Metuchen). Bear left at bottom of exit ramp towards Fords-Perth Amboy. Follow Amboy Avenue past Our Lady of Peace Church (Amboy Avenue is now New Brunswick Avenue). Turn right on King Georges Post Road (Dunkin Donuts on the left). **FOLLOW DIRECTIONS AS ABOVE**.
ROUTE #1 NORTHBOUND: Route #1 North to Edison area and take exit ROUTE 501 (Amboy Avenue-Fords-Perth Amboy) past Our Lady of Peace Church. **FOLLOW DIRECTIONS AS ABOVE**.
NEW BRUNSWICK-HIGHLAND PARK AREA: Woodbridge Avenue East. Take the jug handle exit to Raritan Center. At the bottom of the ramp, turn left on Fieldcrest Avenue. Go through the next traffic light intersection. This is now King Georges Post Road. Follow straight for 1.2 miles to May Street and turn left. **FOLLOW DIRECTIONS AS ABOVE**.
PLAINFIELD AREA: Park Avenue to Plainfield Road. Turn right and follow straight. This turns into Central Avenue. Follow Central Avenue straight to the end (Stop & Shop will be directly in front of you). Turn left then quick right at the next light (Lake Avenue). Follow straight to the traffic light at Amboy Avenue and turn left. Follow Amboy Avenue past Tano Mall and the Fire Station; through the intersection of Amboy and Woodbridge Avenue (Gas station is on right). Continue past Our Lady of Peach Church. **FOLLOW DIRECTIONS AS ABOVE**. **OR**.....
Oak Tree Road to Grove Avenue. Follow Grove Avenue across Route 27, the name will change to Eggert Street. Follow to the end and turn left to Amboy Avenue. You will pass Tano Mall and the Fire Station. The next intersection is the corner of Amboy and Woodbridge Avenue(Gas station on the right). Continue past Our Lady of Peace Church. **FOLLOW DIRECTIONS AS ABOVE**.

OLD BRIDGE OFFICE- 3 HOSPITAL PLAZA, SUITE 415 – OLD BRIDGE, NEW JERSEY 08857

ROUTE #9 SOUTHBOUND: Take Ferry Road exit (Blue "H" sign). Make right onto Ferry Road and proceed approximately one mile. Medical Arts Building on right next to hospital.
ROUTE #9 NORTHBOUND: Take Ferry Road jug handle. **FOLLOW DIRECTIONS AS ABOVE.**
ROUTE #18 SOUTHBOUND: To Ferry Road – make left at light and cross over Route #18. Continue on Ferry Road for approximately 100 yards. Medical Arts Building on left next to hospital.
ROUTE #18 NORTHBOUND: To Ferry Road – make right. Hospital and Medical Arts Building on left.