ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

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

Dear Patients,

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.

- Pre-Op Review- (Please complete prior to your Pre-Op Phone Call 1-2 business days prior to procedure)
- Patient Registration Form- (Please complete prior to your arrival at the Surgery Center)
- Patient Financial Responsibility
- Responsible Adult Companion (RAC)
- Notice of Privacy Practices (Provided at Registration)
- Patient Bill of Rights & Responsibilities (Provided at Registration)

Please make sure you have updated your physician's office staff with any changes in your current address, phone number (home/work/cell,) your primary care physician and insurance information.

You should receive a call 1 to 2 business days before your scheduled procedure from one of our pre-procedure nurses to confirm the time of your arrival. ***Please note that the time provided by your physician's office is TENTATIVE and may change**. If you need a specific time, please make sure to let the physician's office know, and/or call the surgery center at least 3 days prior to your appointment.

If you have not heard from the Center by **2PM the business day prior** to confirm your appointment, please call us at the Center (732) 935-0031.

Should your insurance plan require 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, our services (facility fee,) anesthesia services 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 speak with them, please call our Center and we will assist you in understanding your bill.

Please visit our website at www.advancedendoscopy.com to view our facility, staff & physicians. All necessary forms can be downloaded and printed from our website. The Registration & Responsible Adult Companion (RAC) forms need to be filled out & signed, and all other forms will be signed electronically at the Center.

You **MUST** have a ride home after your procedure. Should your means of transportation be by taxi, you **MUST** still be accompanied by an adult companion to and from the Center. The Taxi driver is **NOT** considered to be your responsible adult companion.

The goal of our staff is to provide you with quality care, and make sure your stay with us is convenient and pleasant.

Sincerely,

Ellen G. Donnell
Administrator

(REVISED 02/2016)

Welcome to Advanced Endoscopy & Surgical Center, LLC. (AESC)

Please review some of the questions you will be asked when the Pre-Op Nurse calls you 1 to 2 days prior to your procedure. You DO NOT have to bring this form on the day of procedure. It is only used for your pre-operative phone call.

In order to make the process easier, please have all the necessary information that applies to you listed on this sheet for when the Nurse calls to go over your health history.

IF YOU DON'T HEAR FROM US BY 2PM THE BUSINESS DAY BEFORE YOUR PROCEDURE YOU MUST CALL AESC AT (732) 935-0031.

Important issues to discuss with the Pre-Op Nurse include:

- *Had any recent colds and infections?*
- *Any chance of Pregnancy?*
- *Had any Anesthesia problems in the past?*
- *Do you have an AICD (Defibrillator), any Transplants, or on Dialysis?*

Health history:

1. Your Weight: _____ Height: _____
2. Do you have any Allergies? _____ If so, what are they: _____

   _____

   LATEX SENSITIVITY (example: rash, redness, dry, itchy skin)

   TRUE LATEX ALLERGY (example: facial swelling, difficulty breathing & hives/blisters)

   ****TRUE LATEX ALLERGY CANNOT BE DONE AT AESC****
3. Last menstrual period (if applicable) _____
4. Diabetic: _____ Insulin _____ Oral Meds_____ Diet Controlled_____
5. Heart conditions: _____

   _____

   Last visit with Cardiologist: _____ Last stress test: _____ Last EKG: _____

   AICD (Defibrillator) / Pacemaker? _____

   ****DEFIBRILLATORS & HEART TRANSPLANTS CANNOT BE DONE AT AESC****
6. Any blood thinners (example: Aspirin, Coumadin, Plavix, Pradaxa)
   When did you last take them? _____
7. Pulmonary (Lung) conditions: _____
8. Kidney problems: _____

   ****DIALYISIS PATIENTS CANNOT BE DONE AT AESC****
9. Neurological conditions/disability: _____
10. History of infectious disease: _____

11. Previous surgeries: _____

12. Problems with anesthesia: _____

13. Sleep apnea: (Do you use C-Pap or Bi-Pap) _____

14. Implanted hardware or device: (example: dentures, total hip or knee replacement, plate, screws, rod) ____

_____

15. Cigarette / Tobacco history: _____

16. Alcohol use: _____

*ALL Medications (including vitamins, supplements & over-the-counter)

Name of Medication	Quantity / Dosage	Frequency
For example: Aspirin	81 mg	Once a day

When you arrive at AESC the receptionist will ask for the following:

1. Completed paperwork for AESC. (Patient Registration & Responsible Adult Companion forms)
2. Your Insurance Cards & Driver's License for Identification.
3. A referral (if needed) for your procedure.
4. Your driver's name and telephone number.

** **IF YOU DO NOT HAVE THE ABOVE ITEMS YOUR PROCEDURE MAY BE CANCELLED****

Thank you in advance for your cooperation,

The Staff at AESC

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.

PATIENT LABEL

_____ _____
Signature of Responsible Party Date

(REVISED 04/2015)

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OUT-OF-NETWORK COMMERCIAL INSURANCE, MOTOR VEHICHLE AND SELF-PAY PATIENTS

Advanced Endoscopy & Surgical Center, LLC. (AESC) 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, AESC will accept the payment received from your insurance carrier(s) as payment in full, and will not bill you for any balance.

IN-NETWORK COMMERCIAL INSURANCE

Please be advised that we participate with Amerihealth, ALL Blue Cross Blue Shield Plans, Tri-Care, Medicare, Railroad Medicare, New Jersey Carpenters, Medicaid, Well Choice Horizon NJ Health and United/Oxford. 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 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 workers' compensation or motor vehicle carrier denies your claim as unrelated.
5) Your insurance carrier mailed payment to you rather than AESC, and you did not forward the payment as instructed below.
6) You have an attorney's letter of protection and the case does not settle in your favor.
7) We have 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-MGIP, ADH-Red Bank, Dianon, ENDO-CDX, Genesis Laboratory and Ocean County Medical Labs.

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

Patient Signature _____ Date _____

(Revised 04/2015)

ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

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

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. This is usually 6 to 8 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 04/2015)

COASTAL HEALTHCARE

3200 Sunset Avenue, Suite 208 Ocean, NJ 07712
Telephone (732) 775-9000 Fax (732) 775-0666

Howard Guss, D.O. **Gagan Beri, M.D.**

DISCLOSURE FORM

Dear Patient:

You have been scheduled to have your upcoming procedure at **Advanced Endoscopy and Surgical Center** (the "Facility"). The following disclosure is made at or prior to the time that the referral is made:

In accordance with Federal Regulations (42 C.F.R. 416.50(a) (ii)) and the Public Law and applicable rules of the State of New Jersey, Board of Medical Examiners (C. 26:2H-12; N.J.A.C. 13:35-6.17) a physician, podiatrist and all other licensees of the Board of Medical Examiners must inform patients of any significant financial interest in a health care service.

The Facility is owned **[IN PART]** by Dr. Guss and Dr. Beri. Accordingly, please take notice that the physician who will be performing your procedure may have a financial interest in the health care service for which you are being referred.

You may, of course, seek treatment at a health care service provider 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.

You have the right to enter into an advanced directive. An advanced directive means a written statement of your instructions and directions for health care in the event of your future decision making incapacity. An advanced directive may include a proxy directive or an instruction directive, or both. (N.J.A.C. 8:43A-1.3).

You have the right to make informed decisions regarding your care including the right to make decisions concerning the right to accept, refuse, or choose from alternative of medical and/or surgical treatment.

By signing this disclosure you or your legal representative, acknowledge that: (1) you are receiving this notice prior to the date of the procedure; (2) you have been informed of the financial interests of the practitioners in this office; (3) you voluntarily desire to have your procedure performed at the Facility; (4) you have been informed that part or all of your procedure will be considered "out-of network", if applicable; (5) you have the right to enter into an advanced directive; and (6) you have the right to make informed decisions regarding your care.
Understood and agreed:

_____	_____	_____, 20___
Patient Signature	Printed Name	Date
_____	_____	_____, 20___
Witness Signature	Printed Name	Date

Complaints may be lodged with the following:

N.J. Department of Health and Senior Service
Division of Health Facilities Evaluation and Licensing
P.O. Box 367
Trenton, N.J. 08625-0367
Complaint Hotline: 1-800-792-9770
http://www.state.nj.us/health/healthfacilities

Office of Medicare Beneficiary Ombudsman
http://www.medicare.gov/Ombudsman/activities.asp

Patient Name: _____ Date: _____ Time: _____

I hereby authorize Dr. Howard Guss / Dr. Gagan Beri _____, ("physician") and such assistants as may be selected to treat the following condition(s): _____

A. The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr. Howard Guss / Dr. Gagan Beri, and I understand the nature of the procedure to be (check where applicable):

- ☐ Flexible Sigmoidoscopy (insertion of tube into rectum/colon) with possible biopsy (tissue sample)
- ☐ Colonoscopy with possible biopsy (tissue sample) or polypectomy (polyp removal) (insertion of tube into rectum/colon)
- ☐ EGD (Esophagogastroduodenoscopy (EGD or Upper Endoscopy) (Insertion of tube into esophagus/stomach/duodenum) with possible biopsy (tissue sample) / cautery /dilation (stretch narrowed area).
- ☐ PEG (Percutaneous Endoscopic Gastrostomy) tube replacement. A non-surgical technique for replacement of a feeding tube.
- ☐ Hemorrhoid Therapy: **A.** Infrared Coagulation (IRC) (An anoscope is put into the rectum to allow the hemorrhoids to be seen. A heat producing instrument is placed on the hemorrhoid tissue & a small controlled tissue burn is made.) **B.** Anorectal Hemorrhoid Ligation (Bands are placed on tissue)

B. It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

***Contrast Radiographic Studies (Barium Enema or GI series)** ***For PEG: Surgical Gastrostomy (feeding tube)**
***Observation (not to do the procedure)** ***For Sclerotherapy / Banding / IRC: Surgery and/or medication**

C. I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

- **Bleeding** (increase if biopsy, polypectomy or sphincterotomy is performed)
- **Perforation (tear a hole inside possibly requiring surgery to be performed). Possible colostomy (opening of a portion of the colon through the abdominal wall to its skin surface to direct to fecal stream through a colostomy bag)**
- **IRC (Bleeding or pain could lead to the need for antibiotics, transfusions, hospitalization or surgery)**
- **Anorectal Hemorrhoid Ligation (Could lead to severe pain, if treatment is too close to anal verge or possible ulceration at banding sites)**
- **Splenic Rupture**
- **Aspiration (fluid entering the lungs)**
- **Missed polyps / lesions or abnormalities**

D. Blood Thinning Medications: The risks of stopping, not stopping or restarting blood thinning medications too soon are inherent risks of any procedure, which can result in the following: **Stroke** **Heart Attack** **Bleeding** **Clotting** **And even death**
Any blood thinning medications that you are taking should be discussed with your physician prior to your procedure. **You are RESPONSIBLE for following your prescribing Physician's instructions regarding blood thinning medications. You are responsible for understanding your medications including their usage, risks and benefits of holding / continuing & restarting your medications.**

E. I have been told if the procedure is not performed, what may happen to me is: **The condition listed above may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding / Tumor / or Growth / Disease)**

F. It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the procedure or any other procedure commenced.

G. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest, etc., that are attendant to the performance of any surgical procedure. I have been made aware that during a procedure, growths, lesions or abnormalities may be missed. I am aware 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 the procedure(s). If any new symptoms occur or old symptoms persist, I am aware that I should seek additional, immediate medical therapy.

H. I consent to the administration of anesthesia and the use of such anesthetics as may be deemed advisable by the physician or anesthesiologist responsible for this service to me. The anesthesiologist is not necessarily a physician as named above. Benefits and risks of anesthesia have been explained. Risks include, but are not limited to changes in heart rate, breathing and/or blood pressure or inflammation at site of injection.

I. I consent to the retention or disposal of any tissue or parts which be removed.

J. I am aware that the admission of other observers to the Operating and/or Procedure room(s) may occur, as approved by my physician.

K. If my physician or member of Advanced Endoscopy & Surgical Center's staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood for the human immunodeficiency virus (HIV) and hepatitis.

L. I have informed Advanced Endoscopy & Surgical Center & my Physician of **ALL** changes in my medical history up to the day of my procedure.

M. I certify that I have read and fully understand the above consent to operate procedure(s): that the explanations therein referred to were made to me by Dr. Howard Guss / Dr. Gagan Beri, and that the statements requiring insertion or completion were filled in. I am in agreement with all of the above unless checked ☐ No If checked No, then the procedure(s) cannot be completed at AESC until further discussion and agreement between the Physician and patient takes place, and a new informed consent is completed.

_____ _____ _____
Signature of Patient or Other Person Responsible **Relationship if Patient Unable to Sign** **Witness Signature**

PHYSICIAN'S CERTIFICATION

I, Dr. Howard Guss / Gagan Beri, certify that I have explained procedure(s), the attendant risks and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

_____ _____
Physician's Signature **Date**

(For AESC Use Only) *****OVER 30 DAY UP-DATE: ( ) PATIENT REMAINS IN AGREEMENT, WITH NO CHANGES*****

_____ _____
Patient Signature **Witness Signature**

_____ _____
Physician Signature **Date**

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