



Charles River Endoscopy Center

is a freestanding ambulatory surgery center dedicated to gastrointestinal endoscopy. Patient satisfaction is our main goal. Our facility was chosen with quality, safety, patient privacy, and convenience in mind. Charles River Endoscopy Center is a member of the American Association of Ambulatory Surgery Centers (AAAHC). We accept most insurance plans.

When you arrive, we must have the **name and telephone number** of the person (must be over 18) who will be driving you home (you may not take a cab by yourself) after the procedure.

A **cell phone** number is preferred.

Please allow 2 hours from time of arrival for pick-up.

However, each procedure is unique and we will call your ride with the pick-up time.

If you are not a fluent English speaker and reader, please bring an interpreter.

**** YOU MUST BRING THE PRE-ADMISSION FORM, AUTHORIZATION FORM (both filled out), YOUR INSURANCE CARD(S), AND YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION OR PASSPORT EACH TIME YOU VISIT OUR OFFICE.**

From Points North:

From Route 9, take Edgell Road / Main St. exit south towards downtown Framingham.

*From lights at Route 9 exit ramp stay on Union Avenue (slight left at light at Franklin, straight thru traffic circle at Maple/Main) until just past Neville Rd. Look for 571 Union Avenue on the left. The Endoscopy Center is on the second floor.

From Points South:

Route 495 North, to Exit 22 Interstate 90 East /Mass Pike (toll road), Take Mass Pike exit 12 to Route 9 East/Worcester Road towards Framingham. Follow directions From Points North beginning at asterisk.

From Points West:

Route 9 East, Follow directions From Points North beginning at asterisk.

From Points East:

Interstate 90 West/Mass Pike (toll road) Take Mass Pike exit 12 to Route 9 East/Worcester Road towards Framingham. Follow directions From Points North beginning at asterisk.



Patient's Bill of Rights *The rights of patient(s) are, but are not limited to:*

- 1) Exercise these rights without regard to sex, cultural, economic, educational, or religious background or the source of payment for the patient's care.
- 2) Considerate and respectful care.
- 3) Knowledge of the physician who has primary responsibility for coordinating the patient's care and the names and professional relationships of other physicians who will be seeing the patient.
- 4) Receive information from their physician about their illness, course of treatment, and prospects for recovery in terms the patient can understand.
- 5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
- 6) Participate actively in decisions regarding their medical care. To the extent permitted by law, this includes the right to refuse treatment.
- 7) Full consideration of privacy concerning the patient's medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
- 8) Confidential treatment of all communications and records pertaining to the patient's care and stay at the Center. The patient's written permission shall be obtained before their medical records can be made available to anyone not directly concerned with the patient's care.
- 9) Reasonable responses to any reasonable requests the patient may make for service.
- 10) Leave the Center even against the advice of the patient's physicians.
- 11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
- 12) Be advised if center / personal physician proposed to engage or perform human experimentation affecting the patient's care or treatment. The patient has the right to refuse to participate in such research projects.
- 13) Be informed by their physician or a delegate of the physician of the patient's continuing health care requirements following the patient's discharge from the Center.
- 14) Examine and receive an explanation of the bill regardless of the source of payment.
- 15) Know which Center rules and policies apply to an individual's conduct as a patient.
- 16) Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- 17) Designate visitors of the patient's choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
 - (a) No visitors are allowed;
 - (b) The facility reasonably determines that the presence of a particular visitor will be detrimental to the health or safety of a patient, a member of the health facility staff, or other visitors to the health facility, or would significantly disrupt the operations of the facility;
 - (c) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.
- 18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have that method of that consideration disclosed in the Center policy on visitation. At a minimum, the Center shall include any person living in the household.
- 19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
- 20) Voice concerns or complaints to the Administrator of Charles River Endoscopy, LLC in writing at 571 Union Avenue, Framingham, MA, 01702 or by calling 508.665.4111.
- 21) If a complaint is not resolved to the patient's satisfaction, you have a right to file a grievance with the MA Division of Health Care Quality at 99 Chauncey Street, Boston, MA 02111 or by calling 800.462.5540
- 22) Or the patient can call or contact the Office of the Medicare Beneficiary Ombudsman at www.qlmedicare.com.



PRIVACY NOTICE

The staff at Charles River Endoscopy, L.L.C. considers it a privilege to provide your care and want you to know that they are committed to keeping your medical information confidential. This notice describes how that information will be used by us during and after your stay.

First and foremost, your medical information will be used chiefly to ensure that the doctors and the nursing staff provide you with the safest and most effective care during your upcoming procedure. In addition, the surgicenter may share or use your information for the following purposes:

1. **TREATMENT:** To coordinate your health care and related services with other providers. As an example, some of your medical information may be sent to other doctors who will be looking after you and facilities, laboratories and pharmacies that provide services to you now and in the future.
2. **PAYMENT:** If needed to obtain payment for the services provided to you at our facility.
3. **TO IMPROVE OUR SERVICES:** The most effective way to improve our care is to do medical and quality assurance audits of the services we provide to individuals like you.

Federal law states that our facility may be legally required to disclose your protected health information for reasons such as: to report suspected abuse, neglect or domestic violence; to conduct health oversight activities by an appropriate agency; in connection with judicial and administrative proceedings; for law enforcement purposes; to medical examiners and related persons; and in the event of serious threat to the health or safety of you or the public.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR MEDICAL INFORMATION

You have the right to inspect and copy your medical information including medical and billing records, unless prohibited or protected by law. Your request must be in writing. We may charge you for the cost incurred by us in complying with the request. If you think there are errors, you may make a request to our Privacy Officer, David Goodman, that the records be amended.

You may submit a written request to the Privacy Officer for Charles River Endoscopy, L.L.C. not to use or disclose certain parts of your medical information for the treatment, payment and audit purposes described above. The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request.

You have the right to instruct us if you do not wish us to disclose your medical information to a family member or close friend if the need should arise. You also have the right to request that we contact and communicate with you in a special way.

You have the right to request an accounting for certain disclosures of your health records made by the center. You also have the right to another copy of this notice with detailed explanations. You may submit a complaint to our Privacy Officer or to the Secretary of Health and Human Services if you believe we have violated your privacy rights.

PRIVACY OFFICER: David Goodman, Nurse Manager, dgoodman@pchi.partners.org or 508.665.4111

Charles River Endoscopy Center, LLC

571 Union Avenue ♦ Framingham ♦ MA ♦ 01702 ♦ 508.665.4111 ♦ www.charlesrivermed.com ♦ fax 508.665.4110

INFORMED CONSENT SAMPLE FORM (physician will go over this information before procedure)

Patient Copy no need to fill out, please read. Thank you.

1. I give my permission to Dr. _____ to perform the following procedure: _____.
2. I understand that during this procedure new findings or conditions may appear and require an additional procedure for proper treatment.
3. Dr. _____ has discussed with me the items below including, but not limited to the following:
 - A. My condition: _____
 - B. Just as there may be benefits to this procedure, I understand that procedures all involve risk. These general risks include, but are not limited to: bleeding, blood clots, tissue damage, perforation, pain, infections, allergic reactions and aspiration.
I also realize that the following additional risks may occur in conjunction with the particular procedure proposed to me: _____.
 - C. I understand and agree to the potential risks involved with the administration of IV conscious sedation. I also understand that the potential risks occur in a minority of cases, these risks include, but are not limited to: decrease or increase in blood pressure, heart rate, irritation to the vein from the IV, respiratory depression, stroke, seizures and even loss of body function or life.
 - D. The alternatives to this procedure and what could happen if nothing is done.
4. I know that other unexpected risks or complications not discussed may occur and that there is no guarantee about the results of the procedure.
5. I understand that I may be transferred to an acute care facility if my physician feels it necessary.
6. I know that the clinical staff may help my doctor during my procedure.
7. Any tissue removed may be examined and disposed of by the center in accordance with accustomed practice.
8. I understand that my procedure may be photographed or videotaped.
9. I understand what my doctor has said and have had all my questions fully answered.
10. Having talked with my doctor and having had the opportunity to read this form, my signature below acknowledges that I consent to the performance of the procedure described above (including medical products that my doctor feels are necessary or advisable).
11. I impose no specific limitations or prohibitions regarding treatment other than those that follow:

No test or procedure is one hundred percent accurate. You must contact your doctor if symptoms persist or you remain concerned about your condition.

X _____ Date _____ Time _____
Patient (or responsible person)

X Dr. _____ Date _____ Time _____
Physician

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AND YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION OR PASSPORT
EACH TIME YOU VISIT OUR OFFICE.**

PRE-ADMISSION QUESTIONNAIRE *please print all information*

Name: _____

PRIMARY CARE PHYSICIAN: _____ ENDOSCOPIST: _____

PROCEDURE: _____ REASON FOR PROCEDURE: _____

MAY WE LEAVE FOLLOW-UP MESSAGES ON AN ANSWERING MACHINE/ VOICEMAIL? YES NO (Circle One)

MAY WE DISCUSS YOUR PROCEDURE WITH ANYONE OTHER THAN YOU? _____

(for example, your spouse, partner, adult child, parent, your medical professional, primary care)

WE MUST HAVE THE NAME AND TELEPHONE NUMBER OF THE PERSON (MUST BE OVER 18) WHO WILL BE DRIVING YOU HOME AFTER THE PROCEDURE, EVEN IF THEY INTEND TO WAIT FOR YOU. WE WILL CALL THEM WITH THE PICK-UP TIME.

Name of Driver (must be over 18) Phone A (cell preferred) Phone B

PLEASE MARK THE FOLLOWING APPROPRIATELY:

PERSONAL HISTORY (SELF)	NO	YES	EXPLANATION, IF YES
HEART DISEASE	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
BREATHING / LUNG PROBLEMS	_____	_____	_____
SEIZURES / STROKES / EPILEPSY	_____	_____	_____
LIVER/ /KIDNEY DISEASE	_____	_____	_____
PERSONAL HISTORY OF CANCER	_____	_____	_____
DIABETES	_____	_____	_____
THYROID PROBLEMS	_____	_____	_____
ARTHRITIS / LIMITATIONS OF MOVEMENT	_____	_____	_____
DIARRHEA / CONSTIPATION	_____	_____	_____
TROUBLE SWALLOWING / FOOD STICKING	_____	_____	_____
SMOKE /DRINK ALCOHOL-IF YES, AMOUNT	_____	_____	_____
PREGNANT	_____	_____	_____
HEALTH CARE PROXY	_____	_____	NAME _____

ALLERGIC REACTION TO MEDICATIONS? NO YES, Give name of medication and type of reaction _____

ALLERGIC REACTION TO OTHER MATERIALS? NO YES Give name of material and type of reaction _____
(i.e. latex, iodine, food, etc.)

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Name: _____

Has the patient had any problems with anesthesia or sedation? NO YES, EXPLAIN _____

Any other medical problems not listed above? _____

Any surgical operations? _____

Has the patient ever been hospitalized for any reason other than surgery? NO YES, EXPLAIN _____

PRESCRIPTION MEDICATIONS

MEDICATION	STRENGTH	TIMES	LAST DOSE		MEDICATION	STRENGTH	TIMES	LAST DOSE

NON-PRESCRIPTION MEDICATIONS (i.e. Herbs, vitamins)

MEDICATION	STRENGTH	TIMES	LAST DOSE		MEDICATION	STRENGTH	TIMES	LAST DOSE

DO YOU HAVE ANY OF THE FOLLOWING?
(please circle appropriate answer)

YES **NO**

- ___ ___ EYEGASSES / CONTACTS
- ___ ___ DENTURES / BRIDGE
- ___ ___ HEARING AIDS
- ___ ___ ASPIRIN WITHIN THE LAST WEEK

ANY ADDITIONAL INFORMATION / FAMILY HISTORY THAT WILL
BENEFIT YOUR PROCEDURE.

X _____ Patient ___ Parent ___ Power of Attorney ___ Legal Guardian

PATIENT / AUTHORIZED SIGNATURE

*****NOTHING TO EAT OR DRINK AFTER MIDNIGHT, THE NIGHT BEFORE THE PROCEDURE*****

*****NO ASPIRIN / IBUPROFEN / ARTHRITIS PRODUCTS OR PRODUCTS CONTAINING THESE FOR ONE WEEK
PRIOR TO THE PROCEDURE WITHOUT PHYSICIAN APPROVAL.**

***UNLESS OTHERWISE ADVISED BY YOUR PHYSICIAN

**YOU MUST HAVE A RIDE HOME WITH A RESPONSIBLE ADULT (OVER AGE 18);
A TAXI WITH A RESPONSIBLE ADULT OTHER THAN THE CAB DRIVER IS ALLOWED.
YOUR RIDE MUST ACCOMPANY YOU, OR BE AVAILABLE BY PHONE AT TIME OF CHECK-IN.**



CHARLES RIVER ENDOSCOPY, LLC

Please fill out at home and bring with you on the day of your visit. Thank you.

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

M / F (circle) DOB: ____/____/____ Age: _____ Married Single Widowed (circle) Home Phone:() _____

Cell Phone: _____ Primary Language _____ *If not English, please bring an interpreter*

Address: _____ Town & Zip: _____

REQUIRED:

Ride Home (name): _____ relationship: _____ phone:() _____
(must be 18 years of age or older)

**** YOU MUST BRING THIS FORM, YOUR INSURANCE CARD(S),
AND YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION OR PASSPORT
EACH TIME YOU VISIT OUR OFFICE.**

AUTHORIZATION AND CONSENT FOR GENERAL TREATMENT AND BILLING

- I wish to be treated at Charles River Endoscopy, LLC. While in the Center, I permit my doctor, Charles River Endoscopy, LLC, its employees, and all other persons caring for me to treat me in ways that they judge beneficial to me. I understand that this care may include tests, examinations, photography, the administration of medication and medical treatment.
- I authorize Charles River Endoscopy, LLC to furnish information from and/or photocopies of my medical record for this treatment which record may or may not contain privileged information, to an insurer, compensation carrier, Social Security Administration or Welfare Agency which may be providing financial assistance for my hospital care.
- I hereby authorize payment directly to Charles River Endoscopy, LLC of any group benefits, private policy benefits, Major medical benefits as determined by the insurance company or Medicare benefits. I also authorize payment directly to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for treatment rendered, but not to exceed regular charges for the services.
I understand that I am responsible to the hospital and physicians of charges not covered by this assignment.
- I permit a copy of this authorization to be used in place of the original.
- I have received a copy of Charles River Endoscopy, LLC's Notice of Privacy Practices / HIPPA.
- I authorize payment of Medigap Benefits to Charles River Endoscopy, LLC for services provided.

X _____
Patient's Signature Date Time (please note am or pm)

If applicable: the patient is unable to sign due to _____

I therefore, consent for the patient (please print name) _____

X _____
Signature of Patient Representative Date Time (please note am or pm) Relationship to Patient
Print name of Patient Representative: _____ ID _____

Witness Date Time (please note am or pm) Print Name of Witness