



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 TO YOUR APPOINTMENT:

THE (FILLED OUT) **PREADMISSION** FORMS, THE (FILLED OUT) **PAYMENT AUTHORIZATION** FORM,
YOUR **INSURANCE CARD(S)**,

YOUR CURRENT, VALID PHOTO ID (DRIVER'S LICENSE OR STATE ID, PASSPORT, or PERM. RESIDENT CARD)

THESE DOCUMENTS ARE REQUIRED FOR YOUR PROCEDURE CHART

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 (towards Framingham Center) (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. Go to the left after leaving the elevator area.

From Points South:

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

From Points West:

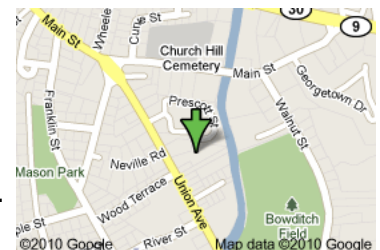
Route 9 East, Follow directions From Points North beginning at asterisk.

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. 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..
- 2) Receive considerate and respectful care without regard to race, sex, culture, economic, educational or religious background.
- 3) Receive private and confidential care.
- 4) Know who is responsible for providing their care. 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.
- 5) Ask for and receive complete and understandable information about their condition and surgery.
- 6) Designate a person to receive information when medically inadvisable to give such information to the patient.
- 7) Participate in decisions regarding their care. If legally authorized, another person can participate in medical decisions.
- 8) Refuse treatment or leave the facility against advice of physician. The right to change physicians.
- 9) Be free from all forms of abuse or harassment..
- 10) Access their medical records, usually within 48 hours. Receive an explanation of their bill.
- 11) Exercise his or her rights without being subject to discrimination of reprisal.
- 12) Receive respect for their cultural and spiritual beliefs.
- 13) Voice concerns or complaints to the Nurse Manager of Charles River Endoscopy, LLC in writing at: 571 Union Avenue, Second Floor, Framingham, MA 01702.
- 14) Patients have a right to be notified of the center's policy on Advance Directives, as required by state or federal law and regulations. Do you have an existing Advanced Directive?..
- 15) Although we respect patients' rights to designate Advance Directives, under the special circumstances of endoscopy, it is Charles River Endoscopy LLC's policy to suspend the Advanced Directive "Do Not Resuscitate" order temporarily during endoscopic procedures and during the immediate recovery period. If you do not have an existing Advanced Directive, we would be happy to provide you the information/documentation from the State of Massachusetts to assist you in drafting one.
- 16) The following physicians have ownership in Charles River Endoscopy Center:
Sergei Aish, Kathlyne Anderson, Prakash Bandari, Usha Bandari, Michael Bean, Joseph Chartor, Alan Cole, Vikas Desai, Katya Divari, Kathryn Ellis, Timothy Ernst, Zoe Fishman, Roberto Jose Flores Cardillo, Gamaliel Garcia, David Gdula, Dolly Geevarghese, Michele Goh, Paul Griffel, Douglas Gronda, Joseph Harrington, Li-Ming Hu, Rohit Jangi, Rasmia Khalid, Shelley Kramer, John Krikorian, Vinay Kumar, Raul Laguarda, Shun-How Lee, Frank Malkin, Anupham Mathur, Richard McMahon, Paige Meisheid, Nicholas Phillips, Christian Potter, Dennis Rapa, Henrique Ribeiro, Veena Shankar, Mohammad Siddiqui, Christopher Smith, John Stevenson, Paul Wright, Young-Ho Yoon and Vincent Yuan..
- 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 this form or bring with you, but please read before you arrive. 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 _____	_____	_____
Patient (or responsible person)	Date	Time
X Dr. _____	_____	_____
Physician	Date	Time

Charles River Endoscopy Center, LLC

571 Union Avenue 2nd floor ♦ Framingham ♦ MA ♦ 01702 ♦ 508.665.4111 ♦ www.charlesrivermed.com ♦ fax 508.665.4110

Please fill out at home and bring this form with you on the day of the procedure. Thank you.

PRE-ADMISSION QUESTIONNAIRE page 2 *Please use blue or black ink*

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.)

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

If you are attaching a list of your medications, please note the last time each medication was taken on that list.
This information is needed for your procedure chart, even if it is "on file", or you filled out forms in the GI office.

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

YES NO

- ____ ____ EYEGLASSES / CONTACTS
- ____ ____ DENTURES / BRIDGE
- ____ ____ HEARING AIDS
- ____ ____ ASPIRIN WITHIN THE LAST WEEK

ANY ADDITIONAL INFORMATION / FAMILY HISTORY THAT WILL BENEFIT YOUR 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)

X _____ Patient ____ Parent ____ Power of Attorney ____ Legal Guardian
PATIENT / AUTHORIZED SIGNATURE



CHARLES RIVER ENDOSCOPY, LLC

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

Please use blue or black pen.

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) even if they intend to stay in the waiting room

PLEASE BRING THIS FORM, YOUR INSURANCE CARD(S), AND

A CURRENT, VALID PHOTO ID (DRIVER'S LICENSE OR STATE ID, PASSPORT, or PERM. RESIDENT CARD)

THESE DOCUMENTS ARE REQUIRED FOR YOUR PROCEDURE CHART

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 Signed Time Signed (please note hour/minutes & 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