

DDA | DIGESTIVE DISEASE ASSOCIATES

We welcome you as a patient to Digestive Disease Associates. Attached, you will find several documents that need your careful attention. Please review, complete, sign and return these forms to our office as soon as possible. This can be done by email to staff@ddabranford.com or by fax to **(203) 481-6788**.

One of the documents asks about an Advance Directive, which is a legal document that provides medical instructions in case you are unable to communicate your wishes. Please indicate whether you have an Advance Directive by circling Yes or No. If you do not have one and would like more information, please check the box indicating your interest.

Cancellation Policy:

- If you need to cancel your procedure, please notify us **at least 3 business days** in advance to avoid a \$100 cancellation fee.
- Cancellations made 24 business hours or less before your procedure, or failure to show up, will incur a \$250 cancellation fee.

Procedure Reminder:

- We will notify you of the exact arrival time for your procedure via MyChart, or by phone, 1-3 days prior to your appointment. We reserve the right to move your appointment to an earlier or later time that day as needed. The day before your procedure we will call and give you the time to be here if your MyChart message wasn't read.

If you have any questions or concerns, please feel free to call our office at 203-481-0315.

We wish you the best of luck with your procedure.

Digestive Disease Associates, LLC

1224 Main Street, Branford, CT 06405

687 Main St., Branford, CT 06405 (Surgical Center Only)

5 Pequot Park Rd. Suite 201, Westbrook, CT 06498

849 Boston Post Rd, Suite 205, Milford, CT 06460

staff@ddabranford.com

Office:203-481-0315

Fax: 203-481-6788

PATIENT REGISTRATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:(Home) _____ (Cell) _____ (Work) _____

EMAIL address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Primary Care Physician (PCP): _____

Emergency Contact Name : _____

Emergency Contact Phone: _____

Emergency Contact Relationship to patient: _____

FINANCIAL AUTHORIZATION:

I understand that I am financially responsible for any remaining balances not covered by my insurance plan. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I agree to pay late payments costs and attorney fees as allowable by law and acknowledge receipt of this agreement.

Date: _____ Signature: _____

DIGESTIVE DISEASE ASSOCIATES ENDOSCOPY SUITE LLC

PATIENT RIGHTS AND RESPONSIBILITIES

We at Digestive Disease Associates Endoscopy Suite LLC place great value on the importance of Patient Rights and Responsibilities. You can be assured we will respect your right to be involved in any decisions pertaining to your medical care and treatment.

PATIENT RIGHTS: You have the right to:

- Respect. This includes your religion, your culture and social beliefs.
- Personal privacy and confidentiality while you are here. You can decide whom you want with you when we talk about your medical care.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment and any act of discrimination or reprisal.
- Voice grievances or complaints regarding treatment or care that is, or fails to be, furnished.
- Be fully informed to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks prior to any procedure.
- If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
- Be fully informed of our Advanced Directive/Living Will policy.
- Make informed decisions regarding your care and to participate actively in decisions about how to manage your pain.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal.
- Be part of a research program and choose not to participate if asked.
- Change physicians at any time.
- Look at your medical records. Your physician will review them with you except when restricted by law.

PATIENT RESPONSIBILITIES: You have a responsibility to:

- **PROVIDE COMPLETE AND ACCURATE INFORMATION TO THE BEST OF YOUR ABILITY REGARDING YOUR HEALTH, MEDICATIONS, ALLERGIES OR SENSITIVITIES.**
- Make informed decisions about any treatment that requires your signature and consent. If you are unable to consent or if a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. This includes experimental treatment. Tell us if you do not understand your care plan.
- Follow the treatment plan of care. You will be given a discharge summary and instructions on how to take care of yourself when you go home.

- Provide a friend or family member to transport you home from the facility and remain with you for 24 hours if advised by a physician.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be considerate of the rights of other patients
- Call after hours only if there is a true emergency or some question that cannot wait until the next day.
- Be courteous and polite to the staff and treat them with the same respect and dignity with which patients are treated.
- Review and Sign all documents required by our Facility including: Patient’s Rights and Responsibility which is posted in the waiting room, HIPAA, Patient’s Financial and Advanced Directive Policies.

Disclosure of Ownership

- Digestive Disease Associates Endoscopy Suite, LLC is privately owned by our physicians who are managing partners and have a financial interest in this facility. This enables them to have a voice in the administration of policies as well as an involvement that helps to ensure the highest quality of surgical care for our patients.

Advance Directive Notification

- Because this facility does only elective procedures, Advanced Directives are not applicable and “Do Not Resuscitate” directives are not honored.
- If you disagree with this facility’s policy, we will be pleased to assist you in rescheduling your procedure at another facility.

Grievances and Complaints

- To file a complaint or grievance about a medical decision, treatment or medical care. You may give your complaint to the office staff, nursing staff, or the physicians. Your care will not be affected by a complaint and we will look into it as quickly as possible. Only substantiated allegations must be reported to the state authority or the local authority, or both.

I understand the above.

***UNRESOLVED COMPLAINTS CAN FURTHER BE REPORTED TO THE STATE AND FEDERAL AGENCIES:**

Complaint/Compliance Unit

**Division of Health Systems Regulation
 Connecticut Department of Public Health
 410 Capitol Avenue, MS#12HSR
 Hartford, CT 06134-0308
 (1-860-509-7552)
 Fax (1-860-707-1916)
 http:www.cms.hhs.gov**

**Federal Health And Human Services Department
 Office of the Secretary
 Medicare Ombudsman
 1-800-MEDICARE
 (1-800-633-4227)
www.medicare.gov/ombudsman/resources.asp**

Name: _____

Date: _____

Signature: _____

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Financial Agreement

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Private insurance and other Health Plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I understand this form and the requested information. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I agree to pay late payments costs and attorney fees as allowable by law and acknowledge receipt of this agreement.

Name: _____

Date: _____

Signature: _____

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NOTICE OF DISCLOSURE AND OWNERSHIP INTEREST

Digestive Disease Associates Endoscopy Suite, LLC and Digestive Disease Associates Pathology Lab is owned by six physicians, Dr. Christopher Illick, Dr. Michael Dorfman, Dr. Keri Herzog, Dr. Kenneth Barshop, Dr. Kristin MacArthur and Dr. Daniel Zanchetti.

Please be advised of the following:

- You have the right to choose where to receive services.
- Two reasonable alternative locations available:
 1. Yale New Haven Hospital at Saint Raphael Campus
 2. Bridgeport Hospital Milford Campus

Do you acknowledge that you have received and understand your Patient Rights and Responsibilities?

YES ___ NO ___

ADVANCE DIRECTIVES

I understand that although I may have an Advance Directive in place, the staff of DDAES, LLC will resuscitate me and send me to the nearest hospital in the event of an emergency even if my Advance Directive dictates otherwise.

Do you have an Advance Directive or Living Will, which is a legal document giving medical advice?

YES ___ NO ___

- If YES - please provide us with a copy on the day of your procedure and we will forward it to the hospital, if transfer is warranted.

OR

- If NO - would you like us to provide information on how to obtain an Advance Directive?

YES ___ NO ___

If you answered Yes, please refer to our website, DDAofCT.com, for a copy of this form, or obtain a copy online at State of Connecticut Office of the Attorney General's Office using the link below:
<https://portal.ct.gov/dmhas/programs-and-services/advocacy/advance-directives>

Patient's Name: _____

Date of Birth: _____

Patient's Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FOR DIGESTIVE DISEASE ASSOCIATES, LLC

This Notice Describes How Medical Information About You May Be Used and Disclosed And How You Can Get
Access To This Information
PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other Individually Identifiable health Information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we may have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes, treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, bill for collection activities and utilization review. An example of this would be sending a bill for your visit to your Insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization s in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, and close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient's Name: _____

Date of Birth: _____

Patient's Signature: _____

Date: _____

This is a copy of the consent form you will review and sign with your physician the day of your procedure. You do not need to fill this out prior to your procedure. This is solely for you to review in advance.

CONSENT FOR OPERATION, ANESTHETICS, AND RENDERING OF MEDICAL SERVICES

DATE _____ ADMITTING DIAGNOSIS _____

PROPOSED PROCEDURE

_____ Colonoscopy _____ Panendoscopy _____ Flex.Sig _____ Polypectomy _____ Biopsy _____ Dilation

I, the above-named patient, hereby authorize the physician at Digestive Disease Associates Endoscopy Suite, LLC (DDAES) and/or associates of his/her choice to perform the procedure indicated above and/or any other therapeutic procedure upon me they may deem necessary or advisable. The necessity for the procedure, the alternatives and potential risk of the operation have been explained to me by the physician and no warranty or guarantee has been made as a result or cure.

I hereby authorize the physician and/or his/her associates to provide such additional services for me as he/she/they may deem necessary or advisable, including procedures different from those now contemplated and including, but not limited to, the administration and maintenance of conscious sedation and the performance of services involving pathology, I hereby consent thereto. Tissue, blood and fluids removed during the procedure may be disposed of or used for science or education; I relinquish all right, title, or interest in those specimens. I also consent, under my doctor's direction, to the application or administration of whatever treatment, dressing or medication that is necessary.

The risks of the procedure include, but are not limited to: bleeding, infection, perforation, aspiration, damage to other organs, sedation reactions, and the possibility of missing a lesion.

PHYSICIANS NOTES:

If I get transported to the hospital, I give permission to discuss my medical treatment at the hospital to a designated representative of DDAES until I am discharged from the hospital

I accept all of the risks referred to above.

Signed at (Time) _____ A.M./P.M.

Date: _____, 20_____

Patient/Parent/Guardian

Attending Physician

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Branford Office (Consultation & Follow up Office Appointments Only)
1224 Lockworks Square, Branford, CT 06405

If using Google Maps or Waze enter "Digestive Disease, Lockworks Square, Branford"

Traveling from New Haven - Take I -95 east to exit 54. Turn right at the traffic light into Cedar St. Continue straight on Cedar St. for 0.6 miles to a stop sign at the end of Cedar St. at the STOP sign make a left onto Main Street about 0.5 miles turn left on Ivy St. into Lockworks Square Parking Lot.

Traveling from New London - Take 1-95 west to exit 54. Turn left at the traffic onto Cedar St. Continue straight on Cedar St. for 0.7 miles to a stop sign at the end of Cedar St. at The STOP sign make a left onto Main Street about 0.5 miles turning left onto Ivy St. into Lockworks Square Parking Lot.

Branford Endoscopy Suite (Surgical Center ONLY)
687 Main Street, Branford, CT

Follow the above directions from 1-95 N & 1-95 S to Cedar St. Continue straight on Cedar St. for 0.6 miles to a stop sign at the end of Cedar St. This will take you to Main Street (St. Mary's Church will be in front of you and The Branford Library will be on your left). Make a right onto Main Street. Our office will be on your left (400ft).

Westbrook Office (Consultation & Follow up Office Appointments Only)
5 Pequot Park Road, Suite 201, Westbrook, CT 06498

Traveling from New Haven - Take 1-95 east to exit 64. Turn left onto Horsehill Road drive over the overpass and you will see Lakebrook Medical Center on your right (first building). Turn right onto Pequot Park Road and then turn right into the parking lot. We are on the second floor.

Traveling from New London - Take 1-95 east to exit 64. Turn right onto Horsehill Rd. you will see Lakebrook Medical Center on your right (first building). Turn right onto Pequot Park Road and then turn right into the parking lot. We are on the second floor.

Milford Office (Consultation & Follow up Office Appointments Only)
849 Boston Post Road, Suite 205, Milford, CT 06460

Traveling from New Haven -Take 1-95 S Follow 1-95 S. Take exit 39A to US-1 S/Boston Post Rd. Turn left into Milford Yale New Haven Health Medical Center. (Building is towards the back)

Traveling from Stamford-Take 1-95 N towards New Haven. Follow 1-95 N Take exit 37 for High Street (signs states for High Street). Turn left onto US-1 S/Boston Post Road. Turn right into Milford Yale New Haven Health Medical Center. (Building is towards the back)

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This endoscopy suite is an *ambulatory surgical center (ASC)*. That means your **copay and deductible** apply here just like they would at a hospital.

Multiple bills for one procedure:

You'll receive:

- A **doctor's fee** (for the physician performing the procedure)
- A **facility fee** (for the use of the endoscopy suite)
- Separate bills from **anesthesia** and **pathology** providers (if you get anesthesia or tissue samples are sent for lab review)

Screening vs. diagnostic colonoscopy:

- A **screening colonoscopy** (routine preventive) might become **diagnostic** if the doctor finds and treats something (like removing a polyp).
- This change may cause your **insurance coverage, copay, or deductible** to apply differently.

Know your insurance coverage:

- The facility does **not confirm or guarantee your benefits**.
- It's **your responsibility** to verify what's covered by your plan.

If your insurance changes:

- You **must notify** Digestive Disease Associates **before your procedure**.
- If you don't, you'll be **personally responsible for the full bill**.
- Many insurers also require **prior authorization**, so check that in advance.

Billing questions:

Call **203-481-0315** if you have questions about charges.

Cancellation and No-Show Policy

We at Digestive Disease Associates Endoscopy Suite, LLC have all of our patients in mind when scheduling your procedure, and because of this we take cancellations and no-shows very seriously.

When scheduling your procedure please keep in mind the following:

1. We require **three Business Days** notice for procedure cancellations. If you do not follow this **policy, you'll be charged a \$100 cancellation fee.**

Monday Procedure - Cancel by Wednesday		Thursday Procedure - Cancel by Monday
Tuesday Procedure - Cancel by Thursday		Friday Procedure - Cancel by Tuesday
Wednesday Procedure - Cancel by Friday		

2. If you cancel within 24 business hours or less before your procedure, or don't show, you will be charged a \$250 cancellation fee

3. We will notify you of the exact arrival time for your procedure via MyChart, or by phone, 1-3 days prior to your appointment. We reserve the right to move your appointment to an earlier or later time that day as needed. The day before your procedure we will call and give you the time to be here if your MyChart message wasn't read.

Patient's Name: _____

Date of Birth: _____

Patient's Signature: _____

Date: _____