Central Illinois Endoscopy Center

Please read the following instructions regarding the information in this packet.
We look forward to seeing you and helping you with your medical needs.

1 | **Retain the back page of this packet regarding DRIVER information.**
Make sure your driver is present with you at check in.

2 | **Do not take anything by mouth 4 hours prior to procedure if you are having a colonoscopy.**
Nothing by mouth 8 hours prior to procedure if you are having an EGD.
If you are having both nothing by mouth 8 hours prior to procedure.

3 | **Please bring your drivers license and insurance card with you.** (for internal office imaging)

4 | **Cancellations**
If you cannot keep your appointment or should you need to reschedule, please call our office at least 48 hours in advance. If you fail to arrive for your appointment twice without calling or should you cancel your appointment three (3) times consecutively, you may be terminated as a patient of Central Illinois Endoscopy.

5 | The information from Central Illinois Endoscopy and Illinois Gastroenterology Institute supplied in this packet is for your review and does not need to be completed prior to your procedure at CIEC. You will sign the forms when you arrive at CIEC for your procedure.

6 | Central Illinois Endoscopy and Illinois Gastroenterology are not the same organization. The Illinois Gastroenterology physician who will perform your procedure is not employed by CIEC. Your insurance company will receive a claim from both CIEC and IGI and you will receive separate explanation of benefits for both claims. If either entity has a balance due after your insurance has paid, you will receive a statement. You and your insurance company were not billed twice for the same service. One bill represents the fee charged by CIEC for the use of the facility (and facility related services) while the other fee is from the physician's office for the professional service provided.

PROCEDURE INFORMATION

Central Illinois Endoscopy Center

Colonoscopy is a procedure that enables your physician to examine the lining of the colon (large bowel) for abnormalities by inserting a flexible tube that is about the thickness of your finger into the anus and advancing it slowly into the rectum and colon. If there are any abnormalities the physician will take an instrument to take biopsies of the lining of the colon. If the physician detects polyps (little growths on the wall of the colon) he will remove them if he is able. Most people have sedation for this and go to sleep but you may feel abdominal pressure, bloating, or cramping. When the procedure is done you will be monitored in the recovery room. The physician will come and talk to you and your driver. You may not remember what the doctor tells you because of the sedation you received.

EGD or Upper GI Endoscopy is a procedure that enables your physician to examine the lining of the upper part of your gastrointestinal tract, the esophagus (swallowing tube), stomach, and duodenum (first portion of the small intestine) using a thin flexible tube with its own lens and light source. This is more accurate than x-ray films for detecting inflammation, ulcers, or tumors of the esophagus, stomach, and duodenum. Depending on your doctor you may have your throat sprayed prior to the procedure as a local anesthetic. Most people are given sedation for the procedure. You may be given this through an IV to help you relax during the procedure. Most people go to sleep. You will be on your left side and the scope will go in through the mouth. Small tissue samples, (biopsies) can be taken to help with diagnosis and treatment of your condition. Biopsies are taken for many reasons and do not necessarily mean that cancer is suspected. You will be monitored in the recovery room and the physician will come and talk to you and your driver after the procedure. You may not remember what the doctor tells you because of the sedation that was given.
For the best (and safest) examination the stomach must be completely empty. ***Do not eat or drink anything 6 hours prior to your procedure. This includes water.***

Flexible sigmoidoscopy is a procedure that enables your physician to examine the lining of the rectum and a portion of the colon (large bowel) by inserting a flexible tube that is about the thickness of your finger into the anus and advancing it slowly into the rectum and lower part of your colon. If you receive sedation for the procedure you may go to sleep but still feel abdominal pressure, bloating, or cramping. If the physician sees an area that needs evaluation in greater detail, a biopsy (sample of the lining) may be obtained and submitted to a laboratory for greater analysis. If polyps (growths formed on the lining of your colon which vary in size) are found, they can be biopsied or possibly removed; however, your doctor may recommend that you have a colonoscopy to do a complete exam of your colon. You will be monitored in the recovery room after your procedure and the physician will come and talk to you and your driver. If you receive sedation for this procedure, you may not remember what the doctor tells you.
You will not be allowed to drive after any procedure you were sedated for.

COLONOSCOPY/FLEXIBLE SIGMOIDOSCOPY/UPPER GI ENDOSCOPY INFORMED CONSENT

Central Illinois Endoscopy Center

You will sign a consent form specific to your procedure prior to the start of the procedure. The form below contains the specific consents and information for each procedure as well as the parts of the consent that are common to each consent form.

I, patient name, date of birth, do hereby authorize IGI Physician and any assistant(s) he/she may designate to perform upon me the procedure of:

- Colonoscopy WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY with the accompanying sedation/analgesia as necessary.
- Flexible Sigmoidoscopy WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY with the accompanying sedation/analgesia as necessary
- Upper GI Endoscopy WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY AND/OR DILATION with the accompanying sedation/analgesia as necessary

1. I understand that this is a procedure performed to examine the inside of my:

COLONOSCOPY - colon, or large intestine. The examination uses a long, flexible fiber-optic lighted tube that allows for viewing inside the colon in order to evaluate its health and diagnose conditions affecting your colon.

FLEXIBLE SIGMOIDOSCOPY- colon, or large intestine. The examination uses a long, flexible fiber-optic lighted tube that allows for viewing inside the colon in order to evaluate its health and diagnose conditions affecting your colon.

UPPER GI ENDOSCOPY - esophagus, stomach and duodenum. The examination uses a long, flexible fiber-optic lighted tube that allows for viewing inside of these organs. The physician inserts the fiber-optic tube into your mouth and moves it into your gastrointestinal tract.

2. I understand that the procedure may not be able to be completed due to poor preparation, disease or other problems.

3. (COLONOSCOPY) I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of a Colonoscopy include but are not limited to:

- Perforation. This is a hole created in the lining of the colon that may require surgery to repair. The risk is increased when there is a biopsy taken or a polyp removed.
- Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This can happen up to 14 days following the procedure. Blood transfusions may be needed if there is a lot of bleeding and may even require another colonoscopy or surgery to repair.
- Discomfort. A small possibility exists that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
- Rare, unusual reactions, such as splenic injury, including possible death, following any endoscopic procedure.
- Infection
- Reactions to the IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin and impaired oxygen delivery.

3. (FLEXIBLE SIGMOIDOSCOPY) I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of a Flex Sigmoidoscopy include but are not limited to:

- Perforation. This is a hole created in the lining of the colon that may require surgery to repair. The risk is increased when there is a biopsy taken or a polyp removed.
- Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This can happen up to 14 days following the procedure. Blood transfusions may be needed if there is a lot of bleeding and may even require another colonoscopy or surgery to repair.
- Discomfort. A small possibility that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
- Rare, unusual reactions, such as splenic injury, including possible death, following any endoscopic procedure.
- Infection
- Reactions to the IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin and impaired oxygen delivery.

3. (UPPER GI ENDOSCOPY) I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of a/an Upper GI Endoscopy include, but are not limited to the following:

- Perforation. This is a hole created in the lining of the esophagus, stomach or duodenum that may require surgery to repair. The risk is increased when there is a biopsy taken, a polyp removed or the esophagus dilated
- Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This is usually minor and can be stopped through the endoscopy. Rarely, surgery is needed to stop the bleeding.
- Discomfort. A small possibility that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
- Rare, unusual reactions, including possible death, following any endoscopic procedure.
- Infection
- Reactions to the IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin and impaired oxygen delivery.
- Broken teeth

4. I understand that the practice of medicine is not an exact science, and no guarantee can be made regarding the outcome of my planned procedure.

5. I understand there are alternatives to this procedure including:

- Colonoscopy - barium enema, flexible sigmoidoscopy and virtual colonoscopy.
- Flexible Sigmoidoscopy - barium enema, colonoscopy and virtual colonoscopy.
- Upper GI Endoscopy - Upper GI barium x-ray is an alternative to this procedure.

6. I understand that if any immediate life-threatening events happen during the procedure, they will be treated accordingly.

7. I understand that a Colonoscopy/Flexible Sigmoidoscopy/Upper GI Endoscopy is not completely accurate and occasionally abnormalities including cancer may be missed and that a Colonoscopy/Flexible Sigmoidoscopy/Upper GI Endoscopy does not provide 100% protection against cancer.

8. A resident (doctor in training) may participate in my procedure, as well as the extent of the resident's participation and I have agreed to the resident's participation. I understand that I may refuse to be involved with the formal training of medical and other students without this affecting my care and treatment in a negative way.

9. I consent to the entering of authorized personnel and observers including students to the procedure room.

10. I consent to the photographing, videotaping, audio or other digital recordings, or the televising of the operations or procedures to be performed including necessary portions of my body for medical, scientific or educational purposes. I understand that my identity will not be revealed by the pictures or the writings that accompany them and I have the right to request the stopping of any recording or filming. I consent to the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming.

11. By signing this I acknowledge that I received and been given written or verbal instructions on the following forms: MD disclosure form, Patient Rights and Responsibilities, Patient Privacy and Advanced Directives.

12. I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I UNDERSTAND THE RISKS, SIDE EFFECTS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL MY QUESTIONS WERE ANSWERED.

PATIENT INFORMED CONSENT AND AUTHORIZATION FOR ANESTHESIA

Central Illinois Endoscopy Center

My provider has explained the risks and side effects of receiving anesthesia and has provided me an opportunity to have all of my questions answered to my satisfaction. I fully understand the risks and side effects explained to me, and I am electing to receive anesthesia for my procedure in order to lessen the pain I would otherwise experience.

1. I understand that regardless of the type of anesthesia used there are a number of common foreseeable risks and consequences which may occur. The following are some, but not all of the common foreseeable risks and consequences which I have been told can occur: (i) sore throat and hoarseness, (ii) nausea and vomiting, (iii) muscle soreness, (iv) injury to the eyes. Further, I understand instrumentation in the mouth to maintain an open airway during anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns and fillings, laceration of the gums or lips.

2. I understand that any medications I am currently taking may cause complications with the administration anesthesia /and/or the procedure that my provider is performing. I understand that it is my best interest to inform my doctors about the nature of any medications I am currently taking including but not limited to aspirin, cold remedies, narcotics, PCP, marijuana, and cocaine.

3. I understand the more serious risks and consequences of anesthesia include but are not limited to; (i) changes in blood pressure, (ii) allergic/drug reaction, (iii) awareness of the surgery, (iv) injury to my baby if pregnant, (v) cardiac arrest and/or respiratory arrest, (vi) brain damage, (vii) paralysis or (viii) death.

4. I acknowledge the anesthesia provider has told me that in his/her medical judgment the type(s) of anesthesia I could receive is/are General/MAC anesthesia and regional anesthetic. I have listened to the anesthesia provider's explanation of the type(s) of anesthesia I may receive, its benefits and common foreseeable risks and consequences as well as those of its alternatives. I now accept his/her recommendation and elect to receive anesthesia.

5. I understand that during my procedure/operation/treatment invasive monitoring may be necessary. I understand the risks and benefits associated with this type of monitoring which have been fully explained to me.

6. I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates to be necessary under the circumstances.

7. I acknowledge I have not eaten or drank anything, not even water, per instructions previously provided to me by my provider and/or center staff unless permitted by the staff.

8. I consent to appropriate tests and treatments which may better evaluate my risk and prepare me for surgery as part of my medical care associated with this procedure/operation/treatment.

9. I understand that my anesthesia care will be given under the supervision of a procedural endoscopist and administered by a Certified Registered Nurse Anesthetists.

10. I, the undersigned patient, give my consent to the provider, its anesthesia group, and their agents to: (i) use or disclose my protected health information ("PHI") to carry out treatment, payment or health care operations; (ii) release information minimally necessary to meet the requested treatment, payment, or healthcare operation need to any other provider or its employees upon a representation that the provider will use the information for treatment or payment; (iii) disclose billing information to an authorized individual that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number; (iv) call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations; (v) discuss my PHI with: (a) any person that accompanies me to a visit or procedure or is present with me when the provider is present, and (b) any person I have identified in advance of any procedure as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, close personal friends, clergy, and patient advocates. I agree that I will not attempt to drive a motor vehicle immediately upon discharge for the facility, and I have arranged for an alternative means of transportation upon discharge.

PATIENT ATTESTATION

By signing this document, I am indicating that I understand the contents of this document and its attachments (if any), agree to its provisions and consent to the administration of anesthesia during my procedure/operation/treatment. I know that if I have concerns or would like more detailed information, I can ask more questions and get more information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology, medicine and surgery is not an exact science and that no one has given me any promises or guarantees about the administration of anesthesia or its results. I fully understand what I am now signing of my own free will.

ANESTHESIA ATTESTATION

I attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the anesthetic and related problems as well as its reasonable alternative(s), if any. Further questions with regard to these anesthetic and related procedures have been answered to his/her apparent satisfaction.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Central Illinois Endoscopy Center

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.

Understanding Your Health Record/Information

Each time you visit a Central Illinois Endoscopy Center (CIEC), a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of information for public health officials charged with improving the health of the nation
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record enables you to ensure its accuracy. Understanding how your health information is used helps you to better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosure to others. By reading this notice and signing the acknowledgement form, you are allowing CIEC to use, access and disclose your health information for treatment, payment, and health operations.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record
- request an amendment to your health record
- obtain an accounting of disclosures of your health information
- request communication of your health information by alternative means or to an alternative location
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction on certain uses and disclosures of your information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or to an alternative location
- protect privacy about a deceased individual as long as the information is maintained

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide a revised notice during registration at your next visit. We will not use or disclose your health information without your authorization, except as described in this notice.

Confidentiality of Information

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected abuse or neglect (of a child or an adult) from being reported under state law to appropriate state or local authorities.

For More Information or to Report a Problem

The CIEC contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

ATTN: Privacy Officer, CIEC | 1001 Main Street, Suite 500B Peoria, IL , 61606

The Privacy Officer can be contacted by telephone at 309.495.1148.

Examples of Disclosures for Treatment, Payment & Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that would work best for you. Your physician will document in your records his or her expectations of the members of your healthcare team. We may contact you to provide appointment reminders or treatment alternatives.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. Patient satisfaction surveys are used to determine how satisfied you are with our service. This survey may be in the form of a telephone call or a written survey.

Uses or Disclosures CIEC may make without Your Authorization

BUSINESS ASSOCIATES: There are some services provided in our organization through contacts with business associates. Examples include a copy service we use when making copies of your health record or a billing service. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

NOTIFICATION: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

COMMUNICATION WITH FAMILY: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

MINORS: We will follow Illinois State Law as it relates to "personal representatives" or non-emancipated minors.

RESEARCH: We may disclose information to researchers when there are established research protocols or where we have obtained a waiver from an institutional review board.

LIMITED DATA SET: We may use or disclose a limited data set (i.e.in which certain identifying information has been removed) of your protected health information for purpose of research, public health, or health care operations. Any recipient of that limited data set must agree to appropriately safeguard your information.

INCIDENTAL USES & DISCLOSURES: We are permitted to use and disclose information incidental to another use or disclosure of your protected health information permitted or required under law.

MARKETING: We may contact you to provide appointment reminders or information about treatment alternatives or

[Continued]

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION *[Continued]*

Central Illinois Endoscopy Center

other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.

FOOD & DRUG ADMINISTRATION (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

WORKERS COMPENSATION: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

PUBLIC HEALTH: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

CORRECTIONAL INSTITUTION: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

LAW ENFORCEMENT: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Your Right to Inspect & Copy: You generally have the right to inspect and obtain a copy of any protected health information in your medical record, information compiled in anticipation of use in a civil, criminal or administrative proceeding and certain other health information which the law restricts CIEC from disseminating.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Examples of Disclosures by Illinois State Law that Require Specific Patient Authorization

In general, release of medical records is restricted except where Federal or State Law allows. The following Medical Records disclosures require your written permission:

- Patients with high blood pressure to the Illinois High Blood Pressure Registry.
- Patients of an Advanced Practical Nurse to the Advanced Practice Nursing Board/Department of Professional Regulation
- Patients of a podiatrist to the Podiatric Medical Licensing Board.
- Patients of an impaired Physician (physical or mental) to the Medical Disciplinary Board.
- Patients who receive genetic testing may have results released to you and to person you designate in writing to receive the information. In the case of minors under 18 years of age, parents/legal guardians may be notified with written permission except where allowed by law.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

CIEC reserves the right to change the terms of its privacy notice and to make the new provisions effective for all protected health information that CIEC maintains.

PATIENT RIGHTS & RESPONSIBILITIES

POLICY

Central Illinois Endoscopy Center believes that health care is a cooperative effort between you as the patient, your physician, and our employees. You are a key member of the treatment team. Recognizing that patients have rights, we have listed below the things you may expect and in turn your responsibilities while a patient at Central Illinois Endoscopy Center.

Central Illinois Endoscopy and medical staff have adopted the following statement of patient rights. These rights are explained to the patient or the patient's representative (as allowed under state law). These rights shall include, but not be limited to:

PATIENT RIGHTS

1. You have the right to considerate and respectful care with dignity and without discrimination, abuse, harassment or reprisal.

2. You have the right to be involved in your plan of care and treatment.

3. You have the right to obtain from your physician complete current information concerning diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information should be made available to an appropriate person on your behalf.

4. You have the right to receive from your physician information necessary to give informed consent prior to the start of procedures and/or treatments involving substantial risks. Except in emergencies, such information for informed consent should include but not necessarily be limited to specific procedures and/or treatments and the medically significant risks involved. Where medically significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information.

5. You have the right to know the name of the person responsible for performing your procedures and/or treatments

6. You have the right to refuse treatment and to be informed of the medical consequences of your action.

7. You have the right to prepare and submit an advance directive, such as a living will, and to choose someone to make decisions for you in case you cannot do so yourself. You may change your mind about health care decisions at any time.

8. You have the right to every consideration of your privacy concerning your own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.

9. You have the right to expect that all communications and records pertaining to your care be treated as confidential except as otherwise provided by law or contractual agreements.

10. You have the right to access information contained in your records, as allowed by policy and by law.

11. You have the right to expect that within its capacity, the physicians and staff will make reasonable response to your request for services. When medically indicated, you may be transferred to another physicians office only after you have received complete information and explanation concerning the needs for and alternatives to such a transfer.

12. You have the right to expect reasonable continuity of care. You have the right to expect your physician or a delegate of your physician to inform you of your continuing health-care requirements following discharge.

13. You have the right to examine and receive an explanation of your bill, regardless of source of payment, and you shall be informed of services for which your insurance policy does not provide coverage.

14. It is CIEC's goal and commitment to provide a safe and secure environment for all our patients, visitors and employees.

15. If you need to communicate problems or issues concerning your medical care, please contact the facility manager.

16. You have the right to change your GI physician if another GI physician is available and agrees to the change.

17. You have the right to refuse to participate in experimental research.

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PATIENT RIGHTS & RESPONSIBILITIES *[Continued]*

Central Illinois Endoscopy Center

PATIENT RESPONSIBILITIES

1. Your physician expects that you or your family will provide complete and accurate information to the best of your ability about your health, any medications including over-the-counter products and dietary supplements and any allergies or sensitivities.

2. In order to facilitate your care and the efforts of your physician and the office employees in their efforts to provide care, you are expected to follow their instructions and medical orders.

3. Duly authorized members of your family are expected to be available to office personnel for review of your treatment in the event you are unable to properly communicate with the physicians or nurses.

4. The office expects that you will cooperate with all personnel and ask questions if directions and/or procedures are not clearly understood.

5. You are expected to be considerate of other patients and office personnel and to assist in the control of noise, smoking, and the number of visitors with you at any one time. You are also expected to be respectful of the property of other persons and the property of the office.

6. It is expected that you will not take drugs which have not been prescribed by your attending physician and administered by office employees and that you will not consume any alcoholic beverages or toxic substances not allowed by your physician during your stay or after your stay as prescribed by your physician.

7. You are expected to observe all safety regulations that you have been made aware of by both verbal and other means.

8. You are responsible to inform the office about any living will, medical power of attorney, or other directive that could affect your care.

9. You are financially responsible for any charges not covered by your insurance.

COMPLAINT/GRIEVANCE PROCEDURE. YOU/YOUR REPRESENTATIVE'S RIGHTS INCLUDE

1. Discussion of any concerns/ dissatisfaction with the care received, which cannot be resolved by available staff, by contacting the Practice Administrator at (309) 495-1184 or ask any staff member to contact them on your behalf.

2. You may also contact the Illinois Department of Public Health 24-hour hotline, 1-800-252-4343 or Illinois Department of Public Health, Office of Health Care Regulation, 525 W. Jefferson Street, 5th Floor, Springfield, IL 62761-0001 or (AAAHC) Accreditation Association for Ambulatory Health Care, 5250 Old Orchard Rd. #200, Skokie, IL 60077 (847) 853-6060.

REFERENCE: CMS Conditions of Participation 416.50(a)
10-2014

STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES & DNR ORDERS

You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare about how you want your medical decisions to be made in the future, if you are no longer able to make them for yourself. A do not resuscitate order (DNR order) is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be used if your heart and/or breathing stops.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health-care facility. Illinois law allows for the following three types of advance directives: (1) health care power of attorney; (2) living will; and (3) mental health treatment preference declaration. In addition, you can ask your physician to work with you to prepare a DNR order. You may choose to discuss with your health-care professional and/or attorney these different types of advance directives as well as a DNR order. After reviewing information regarding advance directives and a DNR order, you may decide to make more than one. For example, you could make a health care power of attorney and a living will.

If you have one or more advance directives and/or a DNR order, tell your health-care professional and provide them with a copy. You may also want to provide a copy to family members, and you should provide a copy to those you appoint to make these decisions for you.
State law requires copies of sample advance directive forms. In addition, this web site provides a copy of these forms and a copy of the Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive.

Health Care Power of Attorney

The health care power of attorney lets you choose someone to make health-care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the "principal" in the power of attorney form and the person you choose to make decisions is called your "agent." Your agent would make health-care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may use a standard health care power of attorney form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your health-care professional or other health-care provider. You should have someone who is not your agent witness you signing the power of attorney.

The power of your agent to make health-care decisions on your behalf is broad. Your agent would be required to follow any specific instructions you give regarding care you want provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instruments regarding refusal of certain types of treatments on religious or other personal grounds; and instructions regarding anatomical gifts and disposal of remains.

Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

Living Will

A living will tells your health-care professional whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serves only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and your health-care professional thinks you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want.

Two people must witness your signing of the living will. Your health-care professional cannot be a witness. It is your responsibility to tell your health-care professional if you have a living will if you are able to do so.

You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

[Continued]

STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES & DNR ORDERS *[Continued]*

Central Illinois Endoscopy Center

Do-Not-Resuscitate Order

You may also ask your health care professional about a do-not-resuscitate order (DNR order). A DNR order is a medical treatment order stating that cardiopulmonary resuscitation (CPR) will not be attempted if your heart and/or breathing stops. The law authorizing the development of the form specifies that an individual (or his or her authorized legal representative) may execute the IDPH Uniform DNR Advance Directive directing that resuscitation efforts shall not be attempted. Therefore, a DNR order completed on the IDPH Uniform DNR Advance Directive contains an advance directive made by an individual (or legal representative), and also contains a physician's order that requires a physician's signature.

Before a DNR order may be entered into your medical record, either you or another person (your legal guardian, health care power of attorney or surrogate decision maker) must consent to the DNR order. This consent must be witnessed by two people who are 18 years or older. If a DNR order is entered into your medical record, appropriate medical treatment other than CPR will be given to you. This web site provides a link to guidance for individuals, health-care professionals and health-care providers concerning the IDPH Uniform DNR Advance Directive.

What Happens if You Don't Have an Advance Directive:

Under Illinois law, a health care "surrogate" may be chosen for you if you cannot make health-care decisions for yourself and do not have an advance directive. A health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, and adult child(ren)), either parent, and adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

The surrogate can make all health-care decisions for you, with certain exceptions. A health care surrogate cannot tell your health-care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition", which is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. A "terminal condition" is an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent and life-sustaining treatment will only prolong the dying process. "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit. An "incurable or irreversible condition" means an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit.

Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment. If your health care surrogate decision maker decides to withdraw or withhold life-sustaining treatment, this decision must be witnessed by a person who is 18 years or older. A health care surrogate may consent to a DNR order, however, this consent must be witnessed by two individuals 18 years or older.

A health care surrogate, other than a court-appointed guardian, cannot consent to certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services.

Final Notes

You should talk with your family, your health-care professional, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives or a DNR order. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive or a DNR order in the future, remember to tell these same people about the change or cancellation.

No health-care facility, health-care professional or insurer can make you execute an advance directive or DNR Order as a condition of providing treatment or insurance. It is entirely your decision. If a health-care facility, health-care professional or insurer objects to following your advance directive or DNR order then they must tell you or the individual responsible for making your health-care decisions. They must continue to provide care until you or your decision maker can transfer you to another health-care provider who will follow your advance directive or DNR order.

PHYSICIAN OWNERSHIP DISCLOSURE

In accordance with Federal ASC Regulations (42 C.F.R. 416.50(a)(ii)), the following ownership disclosure is made in advance of the date of the procedure:

Central Illinois Endoscopy Center is owned in part by the physicians of Illinois Gastroenterology Institute. The physician who will be performing your procedure is an owner of that practice.

You have the option to be treated at another health care facility such as OSF Saint Francis Medical Center, Unity Point - Methodist, or Unity Point - Proctor.

FINANCIAL AGREEMENT

Central Illinois Endoscopy Center

Medically Insured Patient:
As a courtesy to our patients we will bill your insurance company. Please make sure all of your information is correct and up to date with us. Your insurance card(s) need to be presented at the time of your visit. If we are not provided with the correct information, you will be billed and are responsible for the services rendered.

Provider Coverage:
The endoscopy center will pre-certify your procedure to ensure that our facility is covered but pre-certification is not a guaranty of payment. It is the patient's responsibility to know the specific terms and provisions of the coverage provided in the insurance policy. If your insurance denies the claim due to plan provisions or for any reason, you will be responsible for the balance.

Payment Methods:
- We accept cash, check, MasterCard, or Visa.
- Self-pay procedures must be paid in full on or before the day the services are performed other than pathology which will be billed if those services are utilized.
- Payment Plans can be set up if necessary with no interest charged.
- Accounts past due may be assigned to TH Professional and Medical Collections for additional collection activity.

All no-shows and late cancellations will be billed $95. (To avoid charges please notify us within 24 hrs.)
Central Illinois Endoscopy strives to provide the best possible care to our patients. Your understanding of our financial procedures is important to our relationship. If you are unclear of your financial responsibilities or our Financial Policies please feel free to contact our billing department at 309.495.1149.

Please provide CIEC with a contact number you would like your messages left on. If you prefer that a message not be left on a voice mail please specify below. By signing you authorize CIEC to leave a message on he phone number provided.

HIPAA: By signing below I acknowledge that I have been given access to the center's Notice of Privacy Practice.
I hereby authorize CIEC to furnish information to the insurance carrier(s) concerning my illness and/or treatments as required for the processing of medical benefits.

Assignment and COLLECTION FEES: I hereby assign CIEC all payments for medical services rendered to my dependent(s) or myself. I understand that this authorization will remain in effect for as long as my dependent(s) or I remain a patient. I understand that I am financially responsible to CIEC for the charges not covered by this assignment. In the event that I default on payment of my charges, I understand that I am also responsible for any costs incurred in the collection process. If this account is sent to collections, the fees are typically 30 to 50% of my bill, plus court costs and attorney fees, and this charge will be added to my balance due. A photocopy of this agreement shall be as valid as the original.

Central Illinois Endoscopy strives to provide the best possible care to our patients. Your understanding of our financial procedures is important to our relationship. If you are unclear of your financial responsibilities or our Financial Policies please feel free to contact our billing department at (309) 495-1149.

I acknowledge that I have read and agree with the above Financial Policy. I recognize that I am ultimately responsible for the timely payment of my account.

FINANCIAL POLICY & PATIENT AGREEMENT

ILLINOIS GASTROENTEROLOGY INSTITUTE

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Illinois Gastroenterology Institute.

CUSTOMER SERVICE: If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (309) 672-4980 and carefully listen to the prompt. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a $25.00 service charge on all returned checks.

APPOINTMENTS: Please arrive at least 15 minutes prior to your appointment to give yourself time to update your records or complete paperwork required by your insurance. In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment so that we can accommodate another patient's needs.

SELF-PAY PATIENTS (NO INSURANCE COVERAGE): If you have an office visit, we require that you pay $50 **PRIOR** to your office visit appointment. If you can pay for your **office visit** in **full** on the day of your appointment, you will receive a 15% discount.

INSURANCE FILING: As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).

HMO/PPO If we have an agreement with your insurance carrier, we will receive direct payment for covered services. Co-payments are due at the time of service. Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility.. If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and is your responsibility to obtain one. Insurance qualification is different than a doctor referral. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. **If you are having a procedure performed at any of the Unity Point hospitals and a pre-certification for that procedure is required, it is then your responsibility to inform us.** We will then obtain pre-certification for that procedure on your behalf. Precertification is **NOT** a guarantee of coverage. If your insurance company does not pre-cert the procedure, you will be notified prior to the procedure being performed. **It is also your responsibility to inform our staff as to which hospital your insurance requires you to use.**

INDEMNITY-TYPE INSURANCE: Your insurance may or may not agree with the UCR (usual, customary and reasonable) charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. You will be responsible for any remaining balance on your account once your insurance has processed our claim. **Once again it is also your responsibility to inform our staff as to which hospital your insurance requires you to use.**

Billing Statements: Our statements are sent monthly. We allow 60 days for your insurance company to respond to our claim. If they have not responded in that time frame, we will send you a bill for the outstanding amount and ask that you begin making payments on your account while you resolve any payment issues with your insurance company. **In addition to the charge for our services, you will be required to pay the collection agency fees which are typically 33%-50% of the amount owed.**

Copies of Medical Records: We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. Fees for copying records are $35.00 provided they are on site, should we need to retrieve your records from an archive, an additional $10.00 will be applied.

By signing below, I am recognizing that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. This authorization is valid until it is revoked in writing.

ASSIGNMENT OF BENEFITS/MEDICAL INFORMATION RELEASE

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Illinois Gastroenterology Institute, for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. I hereby assign benefits to the doctor or group indicated on this claim. This authorization is valid until it is revoked in writing. Having insurance is **NOT** a substitute for payment. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.

PATIENT SIGNATURE:.....DATE:.....

AUTHORIZATION TO USE & DISCLOSE PATIENT HEALTH INFORMATION

Central Illinois Endoscopy Center

To release the health information of:

Patient Name: _____Phone#:_____Date of Birth: _____

Address: _____

City:_____ State: _____ Zip Code: _____

To release such health information to: ILLINOIS GASTROENTEROLOGY INSTITUTE,

Address: _____

City: _____State: _____Zip Code:_____

Releasing Entity: CENTRAL ILLINOIS ENDOSCOPY CENTER, LLC

This disclosure is: ☐ At the request of the individual patient. ☐ Other: _____

Dates of service:

Authorization to release the following health-related information:

☐ Discharge Summary ☐ Pathology Report(s) ☐ Emergency Record(s) ☐ History & Physical
☐ Operative Report(s) ☐ Itemized Billing Statement ☐ Consultation(s) ☐ Laboratory Report(s)
☐ Progress Notes ☐ Treatment Plan(s) ☐ Visual Depictions of Operative Procedure(s)
☐ Other Records as specified: _____
☐ Entire Medical Record

This Authorization will remain in effect:

☐ From the date of this Authorization until: _____(not to exceed 120 days).
☐ Until the earlier to occur of the date the Releasing Entity fully complies with this Authorization or 120 days from the date of this Authorization.

I understand that:

- the information disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient and is no longer protected by applicable federal and Illinois law.
- I may refuse to sign this Authorization and the Releasing Entity may not condition my treatment on whether I sign this Authorization.
- I may revoke this Authorization in writing at any time. The revocation will be effective when the Releasing Entity receives my written notice, except that the revocation will not affect any prior action undertaken by the Releasing Entity in reliance on this Authorization before the Releasing Entity received my written notice of revocation.

I have read and understand the terms of this Authorization, and I am knowingly and voluntarily authorizing the Releasing Entity to use or disclose my health information in the manner which is described in this Authorization.

_____ _____
Signature of Patient or Legal Representative Date/Time

_____ _____
Signature of Witness Date/Time

_____
If Signed by Legal Representative,
Relationship to Patient

INFORMATION FOR YOUR DRIVER

Central Illinois Endoscopy Center

To make your short stay with us go even smoother please give this informational sheet to you driver prior to your visit.

After arriving with the patient DO NOT LEAVE the Illinois Medical Center premises. Many time doctors and staff may have questions or instructions that the sedated patient is unable to answer.

- The length of stay for most patients is about 2 hours. Some patients are here longer because of more involved procedures. As the driver you will be called to the recovery area to sit with the patient while they recover about 90 minutes after the start of the procedure.
- Feel free to use the vending machine on level 1 of the building for snacks and soft drink items. Just remember the Endoscopy Center waiting area is on level 5 of the building.
- Feel free to help yourself to coffee in the waiting room.
- Free computer wi-fi, cable television and magazines are available in the waiting area. If you have difficulties connecting to the wi-fi please let the staff know and they will find assistance.
- It is common for patients not to remember much of the conversation with the physicians in recovery. Please take the time to go through the information with them.

DIRECTIONS TO:
CENTRAL ILLINOIS ENDOSCOPY CENTER
Illinois Medical Center
1001 Main Street, Peoria IL 61606

Located on the corner of Main Street and U of I Medical Way (near the Unity Point – Methodist Complex across from Methodist Atrium)

- Directions from the East Peoria/Morton area: Merge onto I-74W. Take the IL-29/US-24/Adams St. exit, EXIT 93, toward Jefferson Ave/Downtown Peoria. Merge onto Spalding Ave/IL-29. Take the 1st left onto NE Jefferson/US-24W/IL-29. Continue to follow NE Jefferson Ave. Turn right onto Main St. 1001 Main Street is on the left.
- Directions from the Peoria/Galesburg area: Merge onto I-74E. Take EXIT 92B toward IL-40S/Glen Oak Ave/Downtown Peoria. Merge onto N Knoxville Ave. Stay straight to go onto Fayette St. Turn slight right on NE Glendale Ave. Take the 2nd right onto Main St. 1001 Main St. is on the left. (Your destination is just past U of I Medical Way. If you reach NE Crescent Ave., you've gone too far).
- From the U of I Medical Way: take a quick right onto the ramp leading into the parking lot. We are located on the 5th floor of the IMC Building.