Welcome to Gastroenterology Specialists of Frederick's

Direct Access Colonoscopy

Just about everyone should undergo a screening colonoscopy at age 50, (or age 45 for African-Americans,) on the recommendation of the American Cancer Society. Our Direct Access Colonoscopy program allows healthy patients, with no gastroenterological symptoms, over the age of 50 (age 45 for African-Americans) and weighing less than 300 lbs., to obtain a screening colonoscopy without the extra time and expense of a prior office consultation.

Patients with a strong family history – a first-degree relative (parents, siblings,or children) diagnosed with colon cancer - may also be eligible to participate in the Direct Access Colonoscopy program and should consider screening colonoscopy either at age 40, or when the patient reaches the age of being 10 years younger than when the first-degree relative was diagnosed with colon cancer.

Direct Access Colonoscopy is a great fit for today's busy lifestyles. It is designed to minimize your time off of work or other activities by allowing an appropriate, healthy patient the opportunity of obtaining a screening colonoscopy without coming in first for an office consultation. You save not only time but a copay payment as well by eliminating the office visit. The Direct Colonoscopy screening program is covered by most major insurance plans.

How do I enroll in the Direct Access Colonoscopy program?

If you have read over the above information and feel you may be a good candidate for this program, simply print the Patient Direct Colonoscopy Forms packet and use the cover sheet included to fax the completed forms to our office at 301.663.4602, or they may be mailed to our office.The Direct Colonoscopy packet must be fully completed, including credit card information, in order for the packet to be forwarded on to our physicians for review, prior to scheduling you, if you qualify. An incomplete packet will not be forwarded for physician review until all information is provided. Please make sure that you fill in the Referring Physician to ensure that your primary care physician will receive a copy of your colonoscopy report. A referral from your primary care physician may be required for insurance processing of the claims related to Direct Access Colonoscopy. After the forms are reviewed, you will be contacted and scheduled for either a colonoscopy or an office visit. An office visit may be necessary if a medical condition is identified that will need attention prior to scheduling a procedure. Participation in the Direct Access Colonoscopy program is contingent upon your medical history and pre-procedure insurance approval.

If you are approved for a Direct Colonoscopy, but choose to wait more than 3 months to schedule the procedure, you will need to update our Patient Interview Form, including medications and past medical history, to be reviewed again prior to scheduling.

Most of our procedures are performed in our JCAHO-accredited endoscopy center, Court Endoscopy Center of Frederick, Inc. The center is conveniently located in the same building as our office. See the endoscopy center tab in this website for more information on the center.

Should you have any questions regarding the Direct Access Colonoscopy program, please call our office at 301.663.9440.

Direct Colonoscopy

Gastroenterology Specialists of Frederick, P.A. is pleased to offer Direct Colonoscopy (also known as Open Access Colonoscopy) to help facilitate colorectal cancer screening. Direct Colonoscopy is designed to minimize your time off of work or other activities by allowing appropriate healthy patients the opportunity of obtaining their screening colonoscopy while missing only one day away from work, the day of the colonoscopy. It is appropriate when relatively healthy patients require a screening colonoscopy and an office based gastrointestinal specialty consultation is not necessary. A screening colonoscopy is a colonoscopy being performed to evaluate the colon for polyps or cancer due to one's age or family history of colon polyps or colon cancer. The goal is to find and remove polyps (growths in the colon) and thus reduce (but not eliminate) the risk of colon cancer as most colon cancer starts as polyps. It is NOT appropriate for a patient who is having any gastrointestinal symptoms which may include rectal bleeding, diarrhea, constipation, abdominal pain, change in bowel habits, unexplained weight loss, etc. It is also NOT appropriate for patients with medical conditions such as chest pain, history of heart attack(s), angina, heart stent(s), heart bypass surgery, or uncontrolled high blood pressure; lung or breathing problems, sleep apnea or snoring more than mild, COPD or requiring supplemental oxygen; obesity; kidney disease; stroke; blood thinner medication such as Coumadin/Warfarin; aspirin due to an increased risk of heart attack, stroke, or blood clots; Plavix, Ticlid, Aggrenox.

Colonoscopy is felt to be a relatively safe procedure with an average risk for complications of less than one per cent. Please note that less than one per cent is NOT zero; complications can and do occur. Complications can include:

- Perforation: a hole or tear in the colon. If this occurs, emergency surgery is usually required to repair the hole or tear. This may result in an ostomy, or a bag, which would be attached to your abdomen to collect the stool. This may be temporary or permanent and more than one surgery may be required due to complications or to remove the bag and reconnect the remaining colon.

- Bleeding after the removal of a polyp can occur immediately or even up to 2 weeks after the procedure. This will often stop without intervention but may require blood transfusion, emergent colonoscopy, or surgery.

- Pain from the burn where the polyp was removed. This may require observation in the hospital and antibiotics. It can progress to a perforation requiring surgery.

- Complications from the sedation which could include breathing or blood pressure problems, pneumonia/infection, heart problem or heart attack, stroke, transfer to the hospital from the outpatient endoscopy center, etc.

- Other complications or concerns not listed here.

Other alternatives for colorectal cancer screening are available and include:

- Barium enema: an xray test during which a liquid called barium and air are passed into the colon. This is the test that was performed before colonoscopy was available. Polyps cannot be removed and it is not as accurate as a colonoscopy. If a polyp is found and needs to be removed, a colonoscopy will likely be recommended.

- CT or MRI colonography (or "virtual colonoscopy"): CT or MRI scanning is used to obtain images of the colon. Polyps cannot be removed and accuracy is felt to be less than that of a colonoscopy. If a polyp is found and needs to be removed, a colonoscopy will likely be recommended.

- Sigmoidoscopy and stool cards for blood: Not felt to be as accurate; this scope will see only part of the colon (often less than half of the colon).

- Note that no test is perfect and that all of the above tests, including colonoscopy, can miss polyps and even colon cancer.

CONSENT FOR COLONOSCOPY

You will be required to sign a Consent Form at Court Endoscopy prior to your colonoscopy. This document is part of the process that helps us inform you about this procedure. Please read it and all information carefully and address any questions or concerns you might have directly by contacting the office at least 5 business days prior to your colonoscopy. Please note that the alternative option is to schedule a formal consultation in our office one or more days prior to your colon. This allows for a personal, face-to-face discussion with the provider to review the procedure, its indications, risks, and any concerns you might have or want to discuss. It also allows you the opportunity to reflect upon any of the information you received and decide if any additional information is desired or if you desire not to proceed with the colonoscopy. By opting to proceed with Direct Access Colonoscopy, you acknowledge and accept these limitations and any consequences thereof. Please understand that your physician will speak with you immediately prior to your colonoscopy. However, time constraints will not allow a lengthy or formal consultation regarding any non-

disclosed medical problems or concerns. Please note that if additional information is obtained the day of your colonoscopy, or if there should be a significant change in your medical status since you submitted your forms to our office, there is the risk that your colonoscopy will be canceled if it is felt to be in your best medical interest. Note that submitting the requested documents and information does not result in a formal doctor-patient relationship. The doctor-patient relationship will begin with face to face contact, and mutual agreement as noted by agreeing to proceed with your colonoscopy, at the time of the physical exam and the endoscopic procedure.

You are encouraged to obtain additional information by clicking on the links below:

- American Society for Gastrointestinal Endoscopy It is **HIGHLY RECOMMENDED** to watch the Patient Education Videos of Colonoscopy.
- American College of Gastroenterology Clink on the "Patient Information" tab at the top.
- American Gastroenterological Association At the top left, click on "Patient Center" → "Procedures" → "Preparing for a Colonoscopy"
- National Institutes of Health, National Digestive Diseases Information Clearinghouse Topics to click on include colonoscopy and colon polyps.

We hope you have found this information helpful. Please call us at 301.663.9440 if you have any questions. Thank you for allowing us the privilege of participating in your health care.

GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.

Leonard E. Kane, MD Rebecca Earley-Lee, PA-C

85 Thomas Johnson Ct. Suite B Frederick, MD 21702 301.663.9440 Fax 301.663.4602

FINANCIAL POLICY AND AUTHORIZATION FORM

Physician Professional Fee and Facility Fee

The purpose of this form is to provide you with information about your financial responsibility for your direct colonoscopy. Please understand that payment of your procedure is part of your treatment plan and care.

Patient's Name: _____ **Date of Birth:** _____

1.Physician Professional Fee

In advance of your direct colonoscopy, our practice billing office will discuss with you the estimated cost of the physician professional fee for your direct colonoscopy. Patients are responsible for any deductible and co-insurance amount which is due 10 days PRIOR to the day of your procedure. The billing office can be reached at 301.663.9440, option 4, then option 3.

*** PLEASE NOTE: YOUR PAYMENT MUST BE RECEIVED 10 DAYS PRIOR TO YOUR PROCEDURE DATE, OTHERWISE YOU WILL BE RESCHEDULED!**

The estimate of the physician professional fee that we will provide you is based upon direct or historical information from your insurance company. Please be advised that while we will estimate the approximate cost based upon billing expectations of a screening colonoscopy, billing charges may change if polyps are removed by the physician during the procedure. **When polyps are removed, the screening colonoscopy becomes a diagnostic colonoscopy. It will be submitted with different billing codes and your insurance policy will pay differently.** It is the responsibility of the patient to verify his or her insurance benefits, copays and deductibles with his or her insurance carrier. Benefits are determined by your insurance carrier, not by our office or by our endoscopy center. We recommend that you check the explanation of benefits received from your insurance company to verify any amounts for which you may be responsible.

Your insurance claim should process within 30 days. After the insurance payment is received, we will either charge your credit card/check for any outstanding balance due or refund any overpayment to your credit card, or a refund check will be issued on our next billing cycle.

No –Show and Cancellation Policy:

We request notification of at least 5 business days if you have to cancel your procedure due to an unavoidable circumstance. A missed appointment fee of $100 may be charged without the courtesy of proper notification. This fee will not be applied to any co-insurance, copay, or deductible and is not payable by your insurance company.

2. Facility Fees

In addition to the physician who performs your procedure, there are two or three other entities involved in your procedure. Each entity covers a different part of the procedure process and is billed separately from your physician professional fee. These additional entities are: (1) the facility where your procedure is performed; (2) the anesthesiologist; and (3) if you have biopsies taken during your procedure, the laboratory where the biopsies are sent for testing. You may be responsible for an out-patient facility copay and anesthesia co-pay, based on your insurance benefits. These should be paid on the date of service at the endoscopy center, prior to your procedure. Please call the business office at the endoscopy center at 301.668.1600 if you have questions.

Agreement/Authorization

I authorize Gastroenterology Specialists of Frederick, P.A., / Court Endoscopy Center of Frederick, Inc., Dr. Leonard Kane, and Rebecca Earley-Lee, PA-C to maintain my credit card/ check information on file and to submit charges for any outstanding balances and coinsurances/copays, deductibles owed, as explained in the financial policy. I assign my insurance benefits to the practice/provider listed above.

Patient Signature:_____ **Date:**_____

Credit Card Authorization:

Credit Card Type and Number:_____ Exp. Date:_____

Zip Code _____

Patient's Signature:_____

Date:_____

Witness/ Copy to Patient/ Date/ Initials:_____

FAX COVER SHEET

TO: **Gastroenterology Specialists of Frederick, PA**

Attn: **Direct Colonoscopy Coordinator**

Fax: **301.663.4602**

Phone: **301.663.9440**

From: ____

Phone: ____

Date/Time: ____

No. of Pages: ______________________________(including this cover page)

REGARDING: DIRECT COLONOSCOPY PACKAGE

Direct Colonoscopy Information
Patient Medical Qualification Form
Financial Policy and Authorization
Patient Registration Packet
Copy of photo ID and Insurance card (front and back)

-

Appointment Preference: (Please circle) Monday
Friday
Saturday (1 per month, varies)

First Available

No Preference

GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.

85 THOMAS JOHNSON COURT SUITE B

Leonard E. Kane, MD, FACG, AGAF* FREDERICK, MD 21702-4331 Phone 301.663.9440

Rebecca Earley-Lee, PA-C *Board Certified Gastroenterology Fax 301.663.4602

www.frederickgi.com

MEDICAL QUALIFICATION FORM

Patient Name:_____Date of Birth:_____

Best daytime contact number:_____ Cell:_____ Work:_____

Home number:_____ E-Mail:_____ last 4 digits of SS#_____

AM I A CANDIDATE FOR DIRECT ACCESS COLONOSCOPY ?

Please answer the medical history questions below and return the completed form to our office. If there are no contraindications, you will be assigned to one of our physicians to be scheduled for a colonoscopy. You may need an office appointment if there are medical concerns identified that would require attention before scheduling your procedure. If you are having any symptoms, please call our office at 301.663.9440 to schedule a consultation appointment so that we can discuss any concerns to help optimize your care.

****Please note** that most insurance companies cover screening colonoscopy, but some do not. Please contact your insurance company to find out if you have coverage, or call our office at 301.663.9440 for assistance.

Are you:	AVG.	HIGH
• **At "average risk" for colorectal cancer and between the age of 50 (45 for African-Americans) and 65?** (Definition of **"Average risk":** you have no first degree relative (parents, siblings, or children with colorectal cancer or a certain type of polyp and no personal history of colorectal cancer, polyps, or inflammatory bowel disease.) **Check the " average" risk box.** • **At "high risk" for colorectal cancer and between the age of 50 (45 for African-Americans) and 65?** (Definition of **"High risk":** you have one or more first degree relatives with colorectal cancer or "pre-cancerous" (adenoma) polyps and/or a personal history of inflammatory bowel disease. Physician consultation is highly recommended for people with "High risk" factors for colorectal cancer.) **Check the " high" risk box.**		
If you are at:	Yes	No
• **"Average risk", was your last colonoscopy 10 years or more ago?**		
• **"High risk", was your last colonoscopy 5 years or more ago?**		
Check "no" if you have NEVER HAD a colon exam.		
Do you:		
• **Consider yourself healthy?**		
Are you:	Yes	No
Pregnant or possibly pregnant?		
Taking blood thinners (anticoagulant/antiplatelet drugs ie Coumadin, Plavix, Aggrenox, Lovenox, etc.) or iron supplements?		
A hemophiliac or have problems with bleeding?		
Taking insulin or have diabetes that is difficult to control?		
Experiencing constipation, diarrhea, or change in bowel habits?		
Are you:	Yes	No
Experiencing heartburn or on therapy for reflux?		
On chronic narcotic pain medicines? (If yes, indicate type and how often)		

Do you:	Yes	No
Have a history of difficulty with sedation/ anesthesia?		
Have a history of sleep apnea or use a C-PAP machine while sleeping?		
Have a psychiatric condition that is difficult to control?		
Have blood in the stool, rectal bleeding, black stools or iron deficiency anemia?		
Have a history of heart surgery, artificial heart valve or stent?		
Have a pacemaker or implanted defibrillator?		
Have a history of lung surgery?		
Have a systemic pulmonary shunt or synthetic vascular graft less than one year old?		
Have to limit your activities due to shortness of breath or on oxygen?		
Have conditions affecting your heart, lungs, liver or kidneys (other than high blood pressure or high cholesterol)?		
Have active gastrointestinal symptoms? If yes, describe:		
Have abdominal pain or experiencing nausea or vomiting?		
Have difficulty swallowing?		
Weigh more than 300 pounds?		
Have unexplained weight gain or loss?		
Currently abuse alcohol or drugs?		
Have you:		
Had intestinal surgery within the last 3 months?		
Been hospitalized within the last 3 months?		
Had a flexible sigmoidoscopy within the last 48 months?		
Are you:		
Confined to a wheelchair?		

How did you learn about the Direct Colonoscopy program? _____

Name of your primary care doctor:_____

Name of other doctors you see on a regular or scheduled basis: _____

_____

If you have additional questions regarding Direct Colonoscopy, please contact our office at 301.663.9440.

We will contact you soon after receiving the completed questionnaire. At that time, we will discuss your medical history and schedule your colonoscopy, if appropriate.

Mail to: Direct Access Colonoscopy
Gastroenterology Specialists of Frederick, P.A.
85 Thomas Johnson Ct. Suite B
Frederick, MD 21702

Fax to: (use cover sheet provided)
301.663.4602

Patient Medication Record

Date: _____

Name_____

Phone Number _____

Address_____

_____

Date of Birth_____

Primary Care Physician _____

Allergies	Describe Reaction

List all prescription, over the counter (non-prescription) medications and herbal supplements. Also include any medications which are only taken as needed.

Start Date	Name of Medication (Brand and Generic if available)	Dose (mg, units, puffs, drops, etc)	When /How often do you take this medication?	Purpose	Ordering Physician	Date Stopped taking medication or discontinued	Do any of the medications require special monitoring? (lab testing, frequency, etc)

WELCOME TO
GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P. A.

www.frederickgi.com

Please PRINT the information below to help us serve you better:

Patient's name: _____Today's date: _____

Patient's address (If P.O. Box, please give physical address:

_____

Phone Numbers: Home: _____Work: _____Cell: _____

E-mail address: _____Last 4 digits of SS #:_____

Date of Birth: _____ Age: _____Please Circle: Male/ Female Married/Single/Divorced/Separated/Widow

Pharmacy and phone number _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Emp phone: _____

If patient has a Power of Attorney, please notify the doctor.

Spouse's name: _____ Occupation: _____

Spouse's employer & Address: _____ Phone:_____

Your primary care physician: _____ Other important physicians: _____

Who referred you? _____ Patient's mother's maiden name:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ Relationship: _____

Address: _____Home/Work/Cell phone: _____

Other close relative/friend who does not live with you:_____

_____

INSURANCE INFORMATION

Please submit your insurance card with this form to be copied.
If you do not have insurance, please be prepared to discuss payment options.

KINDLY ALLOW US TO COPY YOUR DRIVERS LICENSE—THE PICTURE HELPS WITH IDENTIFICATION

This information may be used in an attempt to collect a debt and any information obtained may be used for that purpose.

AUTHORIZATION

This is authorization for Dr. Kane or Rebecca Earley-Lee, PA-C to apply for benefits on my behalf. I request that any payments for services rendered to me under any insurance plan, Medicare, Medical Assistance, etc. be made directly to Dr. Kane or Rebecca Earley-Lee, PA-C /Gastroenterology Specialists of Frederick, P.A. until such time as I revoke this authorization in writing. I further authorize the release of any medical information for any claim to my insurance carrier that may be transmitted electronically.

I am aware that Dr. Kane has an ownership interest in the Court Endoscopy Center, LLC.

I authorize Dr. Kane or Rebecca Earley-Lee, PA-C to send a letter to my referring physician or health care provider summarizing his/ her findings, treatment, and recommendations. I further authorize any and all communication between Dr. Kane or Rebecca Earley-Lee, PA-C and my health care providers to facilitate optimal patient care when felt to be in my best interest by Dr. Kane or Ms. Earley-Lee. I understand that I need to complete a formal "Release of Information" form for my chart to be copied and forwarded to another health care provider. A charge may apply for copying of records. I may be contacted with appointment reminders, replies to inquiries, messages regarding test results or treatment, via answering machine or voicemail messages, letters, or email.

If my family (spouse, parents, siblings, adult children) should inquire of Dr. Kane or Ms. Earley-Lee regarding my medical care, treatment issues, etc., I authorize such communication providing Dr. Kane or Ms. Earley-Lee feels such to be in my best interest. PLACE AN "X" OVER THOSE PERSONS, IF ANY, THAT YOU WISH INFORMATION WITHHELD FROM.

I acknowledge that I am responsible for payment of the total bill incurred. I promise to pay my bill in a timely manner as determined by Dr. Kane or Ms. Earley-Lee/Gastroenterology Specialists of Frederick, P.A. and/or office policy. I acknowledge and accept financial responsibility for any and all expenses, direct and indirect, related to collection of my financial obligation, including court costs, attorney fees, collection agency fees, rebilling and administrative fees, loss of wages/salary, etc. **I may be held financially responsible for office appointments not canceled with at least 2 full business days notice ($50) and procedure appointments not canceled with at least 5 full business days notice ($100). I understand that my insurance company will not pay this fee.**

I understand that Dr. Kane or Ms. Earley-Lee may recommend further testing, procedures, future appointments, consultations with other health care providers, treatments, etc. I accept full and complete responsibility if I fail to obtain such recommended testing, procedure(s), consultations, follow-up evaluations, etc., or fail to follow Dr. Kane's or Ms. Earley-Lee's recommendations and advice; I release Dr. Kane and Ms. Earley-Lee and their staff from any consequences that may result.

I understand that I should not take any medication if there is any possibility that I may be or could become pregnant without discussing with Dr. Kane or Ms. Earley-Lee as such could seriously harm my unborn child. Likewise, if there is any possibility that I could be pregnant at the time of an X-ray examination or any other examination, test, or procedure, I need to inform Dr. Kane or Ms. Earley-Lee. I accept any and all responsibility if I fail to take appropriate precautions or so fail to inform Dr. Kane or Ms. Earley-Lee. **Prescriptions will be refilled during regular business hours; please allow 48-hours notice.**

I understand that it is Dr. Kane's and Ms. Earley-Lee's policy to generally acknowledge all testing and lab results, pathology reports, etc., including normal results. If I should not receive such an acknowledgment within a reasonable amount of time, generally 14 days, I understand that it is my responsibility to contact the office to verify that Dr. Kane or Ms. Earley-Lee did receive my results.

I understand and agree to the above, which shall remain in effect until revoked in writing. I may request a copy of this Authorization.

Signature of patient / responsible party: _____

Date: _____

GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.
COURT ENDOSCOPY CENTER OF FREDERICK, INC.

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by signing below.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree with this request, but if we do, we will attempt to honor it.

You authorize communication of your medical care, treatment, billing issues, etc. with your immediate family (spouse, adult children, siblings, parents) or close personal friend so identified by you, when felt to be in your best interest. However, we are not compelled to discuss any issues with your family or authorized friend if we have concerns regarding imparting such information. You may place an "x" over those persons you wish information withheld from.

We may contact you with appointment reminders, replies to your inquiries, messages regarding test results or treatment, or information about treatment alternatives, via answering machine or voicemail messages, letters, or e-mail.

You have the right to revoke your consent in writing. A revocation will not apply, however, to the extent that we have already acted upon the consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

_____ _____

Signature Date

_____

Printed Name

Revision 092313

\GASTROENTEROLOGY SPECIALISTS OF FREDERICK, P.A.

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

Gastroenterology Specialists of Frederick, P.A.

Joyce Farless, Practice Administrator, Privacy Officer 301.663.9440

Effective Date: Sept. 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone unless you have advised us differently in writing.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable

to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in

procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal

complaint to:

Barbara Holland, Regional Manager
Office of Civil Rights, U. S. Dept. of Health and Human Services
150 S. Independence Mall West Suite 372 Public Ledger Building
Philadelphia, PA 19106-9111

Phone 800.368.1019

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.