GASTROENTEROLOGY ATLANTA LLC PATIENT RIGHTS

1. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. Patient may use appointed representative.

2. Exercise these rights without regard to race, sex, cultural, educational or religious background or the source of payment for care.

3. To have considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment.

4. Remain free from seclusion or restraints of any form that are not medically necessary.

5. Coordinate his/her care with physicians and healthcare providers they will see.

6. Receive information from the physician about illness, course of treatment and the prospects for recovery in terms that he/she can understand.

7. Receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment of non-treatment and the risks involved.

8. Have a family member or representative of his/her choice be involved in his/her care.

9. Full consideration of patient privacy concerning consultation, examination, treatment and surgery.

10. Confidential treatment of all communications and records pertaining to patient care. Written permission will be obtained before medical records can be released to anyone not directly concerned with patient care.

11. Access information to his/her medical record within reasonable time frame (48 hours).

12. May leave the facility even against medical advice.

13. Have access to facility grievance process; to communicate any of his/her care problems; to voice grievances regarding treatment or care that is (or fails to be) furnished and receive written notice of the Ambulatory Surgery Center's decision.

14. Be informed by physician or designee to the continuing healthcare requirements after discharge including appointments as well as the physician providing the care.

15. Examine and receive an explanation of the bill regardless of source of payment.

16. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.

17. All facility personnel performing patient care activities shall observe these above rights.

18. To be advised as to the reason for the presence of any individual involved in your healthcare.

GASTROENTEROLOGY ATLANTA LLC PATIENT RESPONSIBILITIES

1. The patient has the responsibility to provide accurate and complete information concerning present complaints, past illnesses, hospitalizations or any other health related issues.

2. The patient is responsible for making it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.

3. The patient is responsible for following the treatment plan established by the physician, including instructions by nurses and other healthcare professionals, given by the physician.

4. The patient is responsible for keeping appointments or notifying the facility/physician in advance if unable to do so and understand that cancelling the procedure within 24 hours may result in a charge of $100.00.

5. The patient accepts full responsibility for refusal of treatment and/or not following directions.

6. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.

7. The patient is responsible for being respectful for the rights of others in the facility.

8. The patient is responsible for following facility policies and procedures.

9. The patient is responsible for notifying the staff if they have any safety concerns.

10. The patient has the responsibility to provide a responsible adult to transport him/her home from the facility.

11. The patient is responsible for informing facility personnel about any living will, medical power of attorney, or other directive that could affect his/her care.

Complaints Against the Physician:

Composite State Board of Medical Examiners
Attn: Ms. Gladys Henderson
2 Peachtree Street, NW, 36th Floor
Atlanta, GA 30303
(404)657-6487

Complaints Against Nursing Staff:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, GA 31217
(478)207-2440

Issues Regarding Medicare: Visit Medicare Ombudsman's Webpage at www.cms.hhs.gov/center/ombudsman.asp or (800)MEDICARE

ADVANCE DIRECTIVES

Adult patients 18 years or older should communicate their wishes regarding advance directives to their significant others. This guides significant others and healthcare providers in following patients' wishes should they become incapacitated or unable to make decisions.

State law recognizes the Georgia Advance Directive for Healthcare, which combines the best features of a Living Will and Power of Attorney for Healthcare into one written document.

❍ Living Will – A legal document informing the physician and health care provider of the lifesustaining treatments or procedures the patient wants when in a terminal condition or a persistently unconscious state.

❍ Appointment of Health Care Proxy (AHCP) – A legal document allowing the patient to appoint another person to make medical decisions should they become temporarily or permanently unable to make those decisions.

❍ Do Not Resuscitate (DNR) – A legal document stating the patient's desire not to have cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. These documents will be collectively referred to as advance directive from here forward.

• The patient is responsible for informing their provider about any advance directive, including a living will and/or medical power of attorney, which may affect their care.

• During the scheduling process, patients or their appointed healthcare proxy will be asked whether they have any advance directives. If so, patients are required to provide the document(s) which will be placed prominently in the patient's chart.

• Patients may request copies of the advance directive they provided by contacting the physician's office.

RELEASE OF INFORMATION

I hereby authorize Gastroenterology Atlanta LLC to release any information acquired in the course of my examination, treatment, procedure to: Any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, or insurance company. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of the authorization upon request.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS

I understand that my insurance company may send payments for the rendered services to me. I hereby assign to the above named physician all surgical, medical insurance, and/or other benefits, if any, otherwise payable to me for their services as described below. I agree to endorse the checks over to the doctor. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to the above named physicians from the obligor of said benefits. Further, I hereby assign and convey to the above named physicians, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct may attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for the above named physician's services from any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I further understand that should any account with Gastroenterology Atlanta LLC be turned

over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

BILLING INFORMATION

There will be three separate billings for any procedure, possibly four separate charges if any biopsies or tissue or cells are removed during the procedure(s).

1. A charge from Gastroenterology Atlanta LLC for your surgeon's fee. This charge is what your physician charges for performing the procedure.
2. A charge from the facility for a facility fee. This charge covers the use of the operating and recovery rooms, equipment, supplies and medications necessary to perform the procedure. It also covers the services of clinical staff.
3. A charge for anesthesia. This charge covers the sedation/analgesia and the anesthetist's charge for administering and supervising the anesthesia services provided during your procedure.
4. A charge for pathology. This charge covers the examination of tissues or cells removed during your procedure.

GRIEVANCE PROCEDURE All alleged grievances will be fully documented, investigated and reported to the persons in authority at Gastroenterology Atlanta. Any substantiated allegation will be reported to the State or Local Authority or both. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of its decision within 10 days which will contain the name of the Gastroenterology Atlanta LLC's contact person. Contact information for the state is included in the Bill of Rights and Responsibilities.