# CONDITIONS OF ADMISSION

## Consent for Medical Diagnostic Studies, Evaluation and/or Treatment:

I voluntarily consent to the procedures which may be performed during this visit to Tulsa Endoscopy Center (TEC), including but not limited to diagnostic, medical and/or surgical treatment under the general and special instructions of my physician. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made about the result of treatments or examinations in TEC. I understand that for Continuous Quality Improvement purposes, some non-personal data relating to my care may be placed into TEC's computer system and may be shared with a national database.

## Consent for Testing for Purposes of Accidental Exposure:

I understand state law allows that in the event a health care worker is exposed to my blood or body fluids during my admission, my blood shall be tested at no cost to me, using a special coded system to ensure confidentiality, for the HIV antibody and other communicable diseases. If such exposure occurs, I will receive additional information about such tests. The results of these tests will not prejudice my patient relationship with the Tulsa Endoscopy Center.

## Release of Responsibility for Valuables:

I understand and agree that TEC shall not be liable, and there is no reimbursement available for the loss of or damage to any of my personal property, such as money, jewelry, documents, glasses, dentures or hearing aids. I have been advised to give all valuables and unnecessary articles of clothing to the person accompanying me for safekeeping while I am at TEC.

## Policy Regarding Payment:

I understand that the physicians providing my treatment at TEC are not employees or agents of the Tulsa Endoscopy Center. Therefore, in addition to Tulsa Endoscopy Center charges, I will receive separate bills for the following physician services: Attending Physician/Surgeon and/or Consulting Physician(s), Pathologist(s), and or other Healthcare Providers. I, the undersigned patient (or responsible party if different from patient) hereby assign and transfer to the Tulsa Endoscopy Center and the physicians involved in my care, any and all right, title and interest in any insurance payments for services provided. It is understood that insurance requirements, such as pre-certification, pre-authorization, or second opinions shall remain my sole responsibility and/or that of my family or legal representative. Regardless of any and all assignments, I agree that I am financially responsible for any charges not covered by insurance benefits, including but not limited to deductibles and coinsurance which are due upon admission. I understand that if Medicare or other insurance companies deny payment, I will be responsible for payment.

## Release of Information:

Tulsa Endoscopy Center is hereby authorized to furnish medical information, as necessary, for the payment of my charges by my insurance carrier, Medicare, Medicaid, or any other payer or agency, from the medical records compiled during my admission. I also authorize release of copies of my medical records to health care practitioners and organizations who are involved in my continued care after discharge. Tulsa Endoscopy Center recognizes that information regarding my health care is confidential. Unless I request otherwise, Tulsa Endoscopy Center will only release my health care information as specified by law. I authorize the staff and physicians of Tulsa Endoscopy Center to discuss my health care information and discharge instructions to the following person(s):_____ I understand that this is not an exclusive list and that if I DO NOT wish my health care information to be disclosed to anyone specifically, then I must document the name of that individual(s) here:_____ I understand that I have the right to obtain copies of my health care information for a fee and after completing the necessary HIPAA Release of Information form.

## Patient Rights and Advance Directives

I have received information regarding my Patient Rights. I have also received information regarding TEC's policies pertaining to ADVANCE DIRECTIVES. Information regarding Advance Directives along with official State documents has been offered to me upon request.

## Disclosure of Ownership Notice

I have been informed prior to the date of my procedure that the physicians who perform procedures at TEC may have ownership interest in TEC. My physician has given me the option to be treated at another facility, which I have declined. I wish to have my procedure(s) performed at TEC.

## Certification:

**I have been instructed and I agree not to operate a motor vehicle, enter into any legal contracts, drink any alcoholic beverage or take any drugs (unless prescribed by a physician) until the morning following my procedure because I have been given narcotics and sedatives. _____ will drive me home from TEC following my procedure and will not allow me to drive because of the narcotics and sedatives I have been given.**

I have read this form, or it has been read to me, and I understand and agree to the above terms and conditions. I certify that the information given to the Tulsa Endoscopy Center for this admission is correct, to the best of my knowledge.

_____ _____
Patient/Authorized Representative Signature Date/Time

_____ _____
Responsible Adult Driver (Print & Signature) Relationship to Patient

Patient Label

_____ _____
Witness Date/Time

# NOTICE OF PRIVACY PRACTICES

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.

**Patient Health Information**
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

**How We Use & Disclose Your Patient Health Information**
*Treatment:* We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
*Payment:* We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
*Health Care Operations:* We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

**Special Uses and Disclosures**
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

**Other Uses and Disclosures**
We may be required or permitted to use or disclose the information even without your permission as described below:
*Required by Law:* We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
*Research:* We may use or disclose information for approved medical research.
*Public Health Activities:* We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
*Health oversight:* We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
*Judicial and administrative proceedings:* We may disclose information in response to an appropriate subpoena, discovery request or court order.
*Law enforcement purposes:* We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
*Deaths:* We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
*Serious threat to health or safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
*Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
*Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
*Business Associates:* We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
*Messages:* We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

**Individual Rights**
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

**Our Legal Duty**
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

**Changes in Privacy Practices**
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

**Complaints**
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

**Contact Person**
If you have any questions, requests, or complaints, please contact:

Lisa Fonkalsrud, BSN, RN, CGRN
Center Director

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement
_____ Date: _____

Version 3.0

Effective Date: May 7, 2013

Tulsa Endoscopy Center LLC

**YOUR OPPORTUNITY TO RECEIVE RELATED HEALTH-CARE INFORMATION VIA E-MAIL**

We often find published health-care information that could be important to you: news stories, studies, tips and other information. With your permission, we are happy to send that information to your e-mail address at no charge.

**What you get**

- A brief electronic newsletter with helpful tips and information
- Alerts to related stories in the news as they happen
- Updates on new discoveries and treatments as they are published
- Any new information you might need to know about us or your health

**You can change your mind**

You can stop the communication from us at any time by clicking an "opt-out" button easily found on each piece we send.

**We won't pester you**

Be assured that you will not receive a mountain of communication from us. It is our intent to send you something on an occasional basis and only if it directly relates to the health-care issues related to your association with us. *And we will not share your address with anyone else.*

**It's free!**

There is absolutely no charge, ever. Complete the information here if you want to be included:
***(* = required)***

*First name: _____
Middle initial: _____
*Last Name: _____
*Primary e-mail address: _____
Birth date: _____

Signature _____ Today's date: _____

# OKLAHOMA NOTICE TO PATIENTS REQUIRED BY THE PATIENT SELF DETERMINATION ACT

This notice is given to you to tell you about your rights, under Oklahoma law, to make medical care decisions. After reading this, you may still have questions. If so, you should ask your doctor and other caregivers those questions.

1. **Who will inform me about my medical care options?** Your doctor must talk about medical care options with you, in terms you can understand.

2. **Who decides what medical care I will get?** As a competent adult, you decide what medical care you will get. You have the right to accept, refuse, or stop any medical care; including life-sustaining treatment, which may prolong your life.

3. **What if I am not able to make my own decisions?** If you can not make decisions about your own medical care, someone must make them for you. An advance directive is the best way to tell people what you want done. You can also name the person you want to make those decisions for you, if you can no longer make decisions for yourself.

4. **What is an advance directive?** An advance directive is a written document you sign while you are still able to make your own decisions. You can use an advance directive to tell people ahead of time what medical care your want. You can also name the person you want to make medical decisions for you, if you can not make them yourself. Oklahoma has three kinds of advance directives: 1. living will, 2. health care proxy, and 3. durable power of attorney for health care. You can have one, two, or all of these advance directives. Oklahoma's living will and appointment of a health care proxy are combined in a form called Advance Directive for Health Care.

5. **What is a living will?** A living will is a document that allows you to state your choices about life-sustaining treatment.

6. **What is a health care proxy?** A health care proxy is a person you name to make medical decisions for you, including decisions about life-sustaining treatment. You appoint your health care proxy by naming them in the Advance Directive for Health Care Form.

7. **What is a durable power of attorney for health care?** A durable power of attorney for health care is a document in which you name the person you want to make routine medical care decisions for you when you can not. Oklahoma's durable power of attorney for heath care is a separate legal document which requires the help of a lawyer. The person you name can also make decisions about life sustaining treatment, if you name that person as your health care proxy using the health care proxy section of the Advance Directive for Health Care Form.

8. **Do I need all of these documents?** The Advance Directive for Health Care Form can cover most situations.

9. **May I refuse tube feeding?** You can be sure that you do not receive tube feeding (artificially administered water, food, or both) by stating your wishes in a living will. You can also do this by appointing a health care proxy to make such decisions for you. If you fail to give express instructions, tube feeding can not be withheld from you except in very limited situations.

10. **Should I sign an advance directive?** Whether to sign an advance directive is entirely your decision. One reason many people wish to sign an advance directive is to avoid a legal dispute if they become ill and can not make their wishes known. Signing an advance directive, or at the very least, talking about your medical care wishes with your loved ones and your doctors before a medical crisis makes good sense.

11. **Can I be sure my instructions will be followed?** If properly signed, your Advance Directive for Health Care is legally binding. If they can not follow your directions, they will make arrangements to transfer your care to others who will.

12. **If I sign an advance directive now, can I change my mind?** Yes, you can give new instructions by writing them down or telling someone. You can sign a new advance directive at any time you want. In fact, you should go over your advance directive at least once a year to be sure it correctly states your wishes.

13. **What if I do not have an advance directive?** If you do not have an advance directive and are unable to make your own decisions, medical decisions will be left to a legal guardian, if one has been appointed. Without an advance directive or court appointed legal guardian, Oklahoma law is not clear about who will make decisions for you. Usually, your family, doctors, and hospital can agree about your medical care.

14. **What if I signed "Directive to Physicians" under the old law?** If you signed a Directive to Physicians under the old Oklahoma law, it is valid and binding under the new law. You may want to sign a new advance directive because it covers more situations. The new law, effective 9-1-1992, allows you to name the person who you want to make your medical decisions.

15. **What if I signed an advance directive in another state?** Advance directives signed in other states are valid and binding in Oklahoma for anything Oklahoma law allows.

# Tulsa Endoscopy Center
# Policy Statement Regarding Patient Right to Self Determination

1. To the extent allowed by law, it is our policy to follow the directions with respect to medical care at the Tulsa Endoscopy Center of our patients who have the capacity to make decisions. You will be considered to have capacity to make health care decisions unless you are unconscious, determined to be incompetent by a court of law, or medically determined by your attending physician to be unable to make health care decisions.

2. Before any non-emergency medical treatment is performed, you have a right to receive from your physician whatever information you need to give your informed consent. The information provided to you should answer your questions about the intended procedure or treatment, the potential risks associated with the treatment, and alternative treatments and their risks. You will be asked to sign a form verifying that you have given your physician your consent to perform the procedure.

3. If you refuse treatment, you will be informed by your physician of significant medical consequences that may result and you may be asked to sign a form regarding your refusal.

4. Should an emergency arise, we will provide life-sustaining care while you are a patient here. Your signed and valid advance directive will be followed, to the extent allowed under Oklahoma Law, once you have been transferred to a higher level of care at the hospital.

5. If you are unable to take sufficient food and water by mouth to keep you alive and are without capacity to make health care decisions, Oklahoma Law considers that you have directed that tube feeding be administered, unless:
    - You have an advance directive specifying the withholding or withdrawal of tube feedings and you are in a condition defined in your directive.
    - Your physician clearly knows or a court finds that when you were competent and with the information necessary make such a decision, you decided that tube feedings should be withheld or withdrawn.
    - The tube feedings themselves would cause you severe, intractable, and long-lasting pain.
    - Tube feedings are not medically possible.
    - You are chronically, irreversibly, and in the final stages of terminal illness.
    - You have an injury in which death is imminent and that death will not be caused by dehydration and starvation.

6. Similarly, if you are without capacity to make health care decisions you will be considered to have directed other life-sustaining treatment be given, unless:
    - You have a valid advance directive and are determined to be in a condition which qualifies you to have treatments withheld.
    - The treatments are considered medically inappropriate or futile.
    - All family members agree that the proposed treatment is not what you would want and your family members have signed a Family Verification to that effect.

If you have any questions regarding our policies, please talk to your physician or nurse.