PATIENT INFORMATION LETTER

Thank you for choosing SPOKANE GASTROENTEROLOGY for your specialty gastroenterology health care. This is our PATIENT INFORMATION LETTER. Please review it and the required additional documents carefully and **bring this letter with you to your appointment or be prepared to sign it at your appointment.**

This will confirm your upcoming appointment with Dr. Preiksaitis for:

□ Gastroscopy (EGD) □ Colonoscopy □ Flexible Sigmoidoscopy □ Other_____

Please arrive 30 minutes prior to your procedure for the intake process.

Our location is: 907 South Perry Street, Suite 260, Spokane WA.

Please be sure you have someone available to take you home. You will NOT be able to drive or travel on your own after the procedure.

If you cancel or reschedule, we require 72 hours' notice otherwise a cancellation fee may be applied – Call: 509-456-5433.

Please read each of the items listed below carefully and **Check Each Item** when you have completed your review. If these documents are not enclosed with this letter, you can find them online at www.spokanegastroenterology.com under "Patient Information". If you have any questions, you can call or ask our staff at the time of your appointment. We will need you to sign below to confirm that you have reviewed these documents before we begin your procedure.

INTIAL HERE

_____ PREPARATION INSTRUCTIONS (VERY IMPORTANT – READ NOW)

_____ ABOUT SPOKANE GASTROENTEROLOGY (2)

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I confirm that I have reviewed and understood the above listed documents. My questions regarding these documents and policies have been answered to my satisfaction. I agree to do my best to comply with these policies. I agree to be treated by the staff and physicians of SPOKANE GASTROENTEROLOGY.

PATIENT OR REPRESENTATIVE*	DATE TIME

*PRINT REPRESENTATIVE NAME & RELATIONSHIP

ABOUT SPOKANE GASTROENTEROLOGY

This practice is owned by Harold Preiksaitis, MD who is a specialist qualified to provide consultations and procedures to investigate and treat gastrointestinal and/or liver diseases. You should know that Dr. Preiksaitis has a financial interest in this facility. Dr. Preiksaitis has many years of specialty training and experience and, together with his outstanding team of nurses and support staff, we will ensure that you receive the best possible care. It is our goal to provide state-of-the-art services focused on your comfort and safety with the least cost to you and your insurer. If you would prefer to communicate in a language other than English, let us know and we will do our best to accommodate your request. If you would like to know more about any of our staff's training or credentials, please ask.

How we work with local hospitals:

Dr. Preiksaitis has privileges at Providence Sacred Heart Medical Center and MultiCare Valley Hospital. He is an independent practitioner but part of the Providence Health Care Team and the MultiCare/ Rockwood Health System. In some cases, you may be advised to have a specific type of procedure done at the hospital because of the availability of specialized equipment, because of other medical conditions you may have or for insurance reasons. Or you may simply choose to have your procedure done at the hospital. It is up to you. You will receive the same great care.

After Hours Care and Emergencies:

This practice does not provide after-hours or emergency care at this facility, although someone will always be available to take your phone call. If you have an urgent need for care after hours, you may be advised to go directly to the closest hospital emergency department or urgent care.

Comments and feedback:

Once you have completed your visit to SPOKANE GASTROENTEROLOGY, please tell us how you found your experience – good or bad – we would like to know so we can keep doing what is good and improve whatever is not. Please direct any comments or feedback to our Nursing Operations Manager.

By phone:	509-456-5433
Email:	on our website at www.spokanegastroenterology.com
Regular Mail:	Nurse Manager, SPOKANE GASTROENTEROLOGY 907 South Perry Suite 260 Spokane WA 99202

Other resources:

HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857

Phone: 360-236-4700
Toll Free: 800-633-6828
Fax: 360-236-2626
Email: HSQAComplaintIntake@doh.wa.gov

Center for Medicare and Medicaid Services (CMS) Office of the Medicare Beneficiary Ombudsman:

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare Help and Support: 1-800-MEDICARE

PAYING FOR CARE AT SPOKANE GASTROENTEROLOGY
Please Read Carefully

Fees for Services:

SPOKANE GASTROENTEROLOGY has contracts with most insurance companies, and we will bill them as a service to you. However, as the patient, you are responsible for any co-pays, deductibles, and any costs that your insurance or Medicare do not cover. If you have Medicare, please request a copy of the required Advanced Beneficiary Notice of Nonpayment which you will need to review and sign. Patients without insurance or insured by a company with whom we do not have an agreement, will be responsible for all charges.

As a free-standing endoscopy facility (ASC or ASF) our costs will be substantially less than hospital-affiliated facilities (HOPD). Our staff will do their best to help you obtain an estimate of your direct costs before you have your procedure. Direct cash payment is available if you have no insurance restrictions. For additional information and rates for cash pay services please ask our staff or visit our website:

www.SPOKANEGASTROENTEROLOGY.com/forpatients/cost

About Your Bill:

If you are having and endoscopic procedure your bill will have three components:

1. Physician Fee: The fee paid to your doctor for performing your procedure.
2. Anesthesia Fee: The fee paid to your anesthesia provider for sedation service for your procedure.
3. Facility Fee: Facility leasing and upkeep, nursing and staff salaries, equipment, drugs, IV supplies and fluids, licensing and certification fees, insurance, taxes, utilities, etc.

Pathology fees are not included. If you are paying directly (cash) for your procedure, these fees may be combined as one bill.

Payment Policy:

All applicable fees are due at the time of service. Unpaid accounts must be paid within 60 days. Past due accounts will be charged 1.5% interest per month (18% per year). Cancellation fees are as follows: office visit $50 with less than 48 hours prior to scheduled appointment, endoscopy procedures $150 with less than 72 hours prior to scheduled appointment. Returned check fee is $25. Insurance companies and Medicare will not pay cancellation fees.

We accept personal check, bank draft, Mastercard, Visa and American Express. Cash payments are accepted if hand delivered to our office. DO NOT SEND CASH BY MAIL. Patients with outstanding amounts owing to the practice will receive only essential care for 30 days after receiving overdue payment notice. Patients should not expect routine further visits, phone calls, lab orders or prescription renewals. Full care will resume when accounts are settled or a payment arrangement has been authorized by the practice. Amounts owing beyond 60 days will be forwarded to collections and will result in dismissal from the practice.

Any patient experiencing financial hardship or problems resolving their accounts can contact this office to arrange a payment plan and continued care conditional upon approval by the practice. If you are experiencing hardship or for any other reason cannot pay, please contact our Billing Associate to discuss payment options.

By initialing and signing the INFORMATION LETTER or signing our SIGNATURE PAD,

You are agreeing to receive medical care including advice and treatment from staff and healthcare providers of SPOKANE GASTROENTEROLOGY.

Furthermore, you agree to accept full financial responsibility as a patient who is receiving medical services.

SPOKANE GASTROENTEROLOGY SAMPLE CONSENT FOR ENDOSCOPIC PROCEDURE

You have the right to know about your condition and the procedure(s) your health care provider has recommended. This consent form is intended to ensure that you are well-informed about the objectives, alternatives, risks and hazards so you can make an informed decision about your care.

I voluntarily request & authorize Dr. Harold Preiksaitis and such associates, assistants, and other providers as needed to treat my condition as noted here by the following procedure(s):

Condition/Indication:_____

□ **Gastroscopy:** After IV sedation, a flexible lighted instrument will be passed through my mouth and advanced into my esophagus, stomach and duodenum to visually examine these organs.

□ **Colonoscopy:** After IV sedation, a flexible lighted instrument will be passed through my anus (or stoma) and advanced into my large intestine (colon) to visually examine it.

□ **Flexible Sigmoidoscopy:** After IV sedation, a flexible lighted instrument passed through my anus will be advanced into my lower large intestine (colon) to visually examine only the last part.

I understand that tissue (biopsies, polyps) may be removed for analysis, photographs may be obtained, and other, additional procedures may be done at the discretion of the doctor for any unforeseen condition encountered during the procedure, including stretching (dilation) of an abnormally narrowed part of my gastrointestinal organs. I further authorize the doctor to do whatever he deems advisable during my procedure in the interest of my best care. I consent to the disposal of any removed tissues.

Endoscopic procedures in general very safe, but I recognize the potential complications of endoscopy including but not limited to perforation, bleeding, diagnostic error, pain, infection, blood clots, allergic reaction, and even death. If sufficiently serious, any of these complications could require a hospital stay, antibiotics, blood transfusion, repeat procedure and/or surgery.

I know that sedation involves additional risk, including over-sedation, aspiration (inadvertent material in the airway), drug reaction, brain damage or death. I may decline sedation. I understand that no warranty, guarantee, or assurance has been made to me as result or cure.

Alternatives to the planned endoscopic procedures have been explained and include, but are not limited to: X-ray tests, rigid proctoscopy/sigmoidoscopy, MRI, nuclear scans or observation alone. These alternatives are not equivalent to endoscopy and do not allow for removal of tissue (biopsy or polypectomy) or other endoscopic treatments. I realize that the alternatives are also associated with risks including, but not limited to: missed diagnosis, radiation exposure, perforation, pain, etc. I recognize that there is risk in continuing my present condition without diagnosis or treatment.

In the event of an urgent transfer to another medical facility, I authorize SPE PLLC to transfer all medical records, photographs, findings, etc. deemed important to facilitate my further care.

I certify that I have read (or heard) and understood this Consent. It is complete and can be altered only with my additional consent. Exclusions (stroked-through) and annotations have been authorized by my initials. All my questions regarding this Consent and the procedure(s) have been answered to my satisfaction, and I have sufficient information to willingly authorize the procedure(s). I know I can withdraw this Consent at any time.

PATIENT OR REPRESENTATIVE*	PHYSCIAN ENDOSCOPIST
*PRINT REPRESENTATIVE NAME & RELATIONSHIP	WITNESS DATE TIME

ANESTHESIA SAMPLE CONSENT

REST ASSURED ANESTHESIA LLC IS A CONTRACTED ANESTHESIA PROVIDER. THEIR BUSINESS ENTITIY IS SEPARATE FROM SPOKANE GASTROENTEROLOGY. THEY WILL INDEPENDENTLY BILL YOUR INSURANCE COMPANY FOR THEIR SERVICE AND YOU WILL BE RESPONSIBLE FOR ANY PORTION OF THEIR FEE NOT COVERED BY YOUR INSURANCE.

1. **I understand** that Rest Assured Anesthesia LLC, an independently practicing group of anesthesia providers will provide anesthesia services for me as necessary to assist my doctor in performing the procedure(s) as described on SPOKANE GASTROENTEROLOGY Consent for Endoscopic Procedure.
2. **I agree** that Rest Assured Anesthesia LLC can bill my insurance for this anesthesia service. Furthermore, **I understand** that I will be personally responsible for any amount billed and not paid by my insurance.
3. **I understand** all types of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my anesthetic, surgery or procedure. Although rare, unexpected and severe complications can occur with anesthesia, which include but are not limited to: heart attack, congestive heart failure, arrhythmias, endocarditis (infection of the heart), bronchospasm, aspiration, pneumonia, respiratory arrest, post-operative ventilation, lost airway, blood clots, lung trauma, sore throat, dental and/or vocal cord trauma, stroke, paralysis, loss of limb sensation and/or function, nerve injury, positioning injury, eye trauma and/or blindness, seizures, awareness during surgery/procedure, temporary memory loss, confusion, discomfort/pain, muscle ache, headache, nausea/vomiting, vegetative state, brain death, kidney failure, allergic reaction, infection, bleeding, blood/blood product transfusion reaction, malignant hyperthermia, death.

1. For known and yet unknown pregnant patients: **I understand** exposure to anesthetic agents can cause pre-term labor and/or spontaneous miscarriage/abortion and certain anesthetic agents may lead to fetal developmental abnormalities. Because these are known risks, a pre-operative urine or blood pregnancy test will be performed at the time of admission to the pre-operative area on all menstruating females, with the exception of those having had surgical sterilization. The surgeon will report the results to the adult/emancipated minor. If the patient is a minor the results will be reported to both the patient and patient's parent/legal guardian. ☐ I understand the risk and refuse a pregnancy test.
2. **Anesthesia Plan: Moderate Sedation/Analgesia ("Conscious Sedation")** which is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Risks include: Nausea/vomiting, dental/vocal cord trauma, sore throat, awareness during surgery, aspiration, pneumonia, bronchospasm, allergic reaction, and transient deep sedation.
3. **I understand** unforeseen circumstances and/or changes in my medical status or surgical needs may occur necessitating modification of the planned anesthetic technique to optimize my safety and/or comfort.
4. The pertinent risks, benefits and alternatives for my planned anesthetic have been explained to me. I have read the above information and all of my questions have been satisfactorily answered.

I hereby consent to the indicated anesthesia plan and/or procedure(s) and any modification(s) to the above as determined by my anesthesia provider to optimize my safety and comfort.

Patient Signature:_____Date:_____Time:_____

Signature of person authorized to consent for the patient: _____Date:_____Time:_____

Witness Signature:_____Date:_____Time:_____

HEALTH INFORMATION PRIVACY (HIPAA) POLICY BRIEF PATIENT SUMMARY

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires all health care providers to provide patients with a clear, user friendly explanation of your rights with respect to your Personal Health Information (PHI). Below is a summary of SPOKANE GASTROENTEROLOGY HIPAA Policy and Practices. Please review this carefully. You will be asked to choose from several options:

1. **You have the option to receive the complete and more comprehensive HIPAA Policy statement so that you can review it in detail. Please contact our office for further information.**
2. **You can refuse to accept our HIPAA Policy in which case we cannot provide medical care to you. Please inform our office if you choose this option.**
3. **You can acknowledge and agree to this HIPAA Policy and Practices. In this case, please initial and sign the INFORMATION LETTER.**
4. **You can withdraw your acceptance of the HIPAA Policy at any time. This needs to be done in writing and cannot be retroactive. Please contact our office for further information.**

We may use and share your PHI for the following reasons:

- To treat your condition
- Bill your insurance for our services
- Help with public health and safety issues.
- Comply with the law.
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.
- We will use or share only those aspects of your PHI required for the specific request/reason.

You have the right to:

- Get a copy of your medical record on paper or as electronic media.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this Health Information Privacy (HIPAA) Policy - Brief Patient Summary.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

You can choose to limit the way that we use and share your information. Please let us know your preferences. Here are some examples of how your information might be shared.

- Tell family and friends about your condition.
- Provide emergency care or disaster relief.
- Send information to your primary care provider or other health care providers you see.
- Send information to a health care provider you are being referred to for further care.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Or contact our office at 509-456-5433

PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to…

- Receive care that meets the high standards set by SPOKANE GASTROENTEROLOGY.
- Care that respect you as an individual, your dignity, values, beliefs, culture and responds to your needs for spiritual care.
- Clear communication regarding your health care at this facility including being informed by your treating provider about any unanticipated outcomes. Any communication restrictions imposed to protect your health & safety will be documented & explained to you & your family.
- Confidentiality, privacy and security. Information about your care and treatment will be shared only with you and/or those responsible for your care.
- Have us recognize and assist you with special needs.
- Protection from abuse, harassment or neglect and access to protective services.
- Be involved in, and agree to, all aspects of your care, including treatment decisions and the right to refuse any or all treatment.
- Be free from any act of discrimination or reprisal.
- To refuse to participate in any research studies without fear of retribution or denial of care.
- Be informed about treatment options, anticipated effects on your health and potential or real adverse outcomes.
- To change providers.
- Be involved in resolution of problems with any care decisions, complaints or conflicts, and a right to timely resolution of such issues; usually within 48 hours.
- Compliance with your expressed wishes regarding family or representative input in your decisions, your legal directives, or court-issued orders.
- Know that physicians treating you own this facility and thus have a financial interest in South Perry Endoscopy PLLC (DBA Spokane Gastroenterology).
- Complain about your care or treatment without fear of retribution or denial of care. You, any family member or representative will be involved in decisions regarding how your complaint is resolved. You are encouraged to communicate any of your concerns to your physician or any of our staff. You may also contact The Washington State Department of Health and/or the Office of the Medicare Ombudsman. Contact information is provided on the adjacent notice and will be given to you upon request.
- If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

As a patient it is your responsibility to…

- Be accurate and complete in giving your medical history and to notify your provider of any changes in your health status or health-related information.
- Ask questions and take part in your healthcare decisions and to notify your provider if you do not understand any part of your treatment.
- Tell your caregivers if they have not fulfilled their commitment to your care or shown concern and respect for you.
- Provide appropriate, valid identification when requested.
- Treat other patients and our staff with respect. To honor their right to privacy and treat other patients' medical information as confidential.
- Review your billing statement and ask related questions. If you are unable to pay your bill promptly, you must contact this office to discuss your options.

IMPORTANT INFORMATION ABOUT THE ADVANCE DIRECTIVE

An Advance Directive is a legal document informing others of your wishes regarding medical treatment and who can make decisions on your behalf.

There are several types of Advance Directives documents and these can include:

1. A **Living Will** is a legal document that tells your doctors, nurses and other health care providers what treatments you would want to have or what treatments you would refuse, should your condition become terminal or if you are in a permanent vegetative state. A living will is not the same as a "Do Not Resuscitate" (DNR) order.
2. **Durable Power of Attorney for Health Care** is a legal document in which a patient appoints another person to make medical decisions on their behalf should they be temporarily or permanently unable to make decisions. This document applies to health care decisions only. In some jurisdictions the Living Will and Durable Power of Attorney for Health Care are contained in one document.
3. **Physician Orders for Life-Sustaining Treatment (POLST)** as a legal document which must be signed by a patient's primary care provider, physician assistant or nurse practitioner and informs other treating doctors, emergency medical staff, nurses and other health care providers whether the patient wishes to be resuscitated in the event that the heart stops or breathing ceases as well as which specific medical interventions are desired. This document is a permanent statement of the patient's wishes regarding resuscitation and remains in effect both in and out of Health Care facilities until the patient and/or patient's doctor revokes or modifies it. A POLST Form should be available from your primary care provider.

We at SPOKANE GASTROENTEROLOGY will comply fully with the law and always respect and follow each patient's wishes. If you have an Advance Directive, please bring that document with you so it can be transferred to a hospital in the unlikely event that that becomes necessary. A copy with be incorporated into your electronic medical record and be available for review by your treating physician and staff and for future reference when it is needed.

Procedures done at SPOKANE GASTROENTEROLOGY would rarely result in situations in which Advance Directives or DNRs will be an issue. ***However, if you experience a negative reaction that is judged by the treating physician or sedating provider to be a direct result of the procedure or the drugs administered, every effort will be made to support your vital signs until the effects are reversed or wear off. Such events may include but are not limited to allergic reactions, inadvertent over-sedation, low blood pressure, seizure, slowed or stopped respirations.*** Contrariwise, if you happen to suffer a cardiac arrest or sudden death by chance while in our facilities and not undergoing a procedure AND you have provided a clear Advance Directive regarding such an event, your wishes as described in that document will be honored.

IF YOU HAVE ANY QUESTIONS REGARDING THIS POLICY, THE ADVANCE DIRECTIVE LAWS OR YOU NEED ASSISTANCE IN OBTAINING FORMS OR OTHER INFORMATION, PLEASE ASK ONE OF OUR STAFF.

Additional information and resources can be found at:

https://wsma.org/advance-directives
https://www.dshs.wa.gov/altsa/home-and-community-services/legal-planning

NOTIFIER: SPOKANE GASTROENTEROLOGY (South Perry Endoscopy PLLC)	LASTNAME, Firstname Initial: DOB: CHART NO:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Medicare does not pay for all services, even those your health care provider has recommended and you would like to have. Medicare may not pay for **Colonoscopy,** for the reasons stated below. If Medicare does not pay, you will be responsible for paying the entire cost of the service.

D.	E. Reason Medicare May Not Pay:	F. Cost Estimate
Screening Colonoscopy	**Medicare will pay for one Screening Colonoscopy every 10 years only**	**$1,150**
Surveillance Colonoscopy	**Medicare will pay for a high risk screening colonoscopy or surveillance colonoscopy every 2 years only.**	**$1,150**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Colonoscopy**.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Colonoscopy** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Colonoscopy** above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **Colonoscopy** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (Exp. 03/2020) No. 0938-0566