EVERGREEN
ENDOSCOPY CENTER, LLC

Patient Acknowlegment & Consent for Use & Disclosure of Protected Health Information

Name: _____ Date of Birth: ____/____/____

How may we contact you?

Home Phone: _____
- □ DO NOT leave a message
- □ Leave a brief message, return #
- □ May leave a detailed message

Cell Phone: _____
- □ DO NOT leave a message
- □ Leave a brief message, return #
- □ May leave a detailed message

Work Phone: _____
- □ DO NOT leave a message
- □ Leave a brief message, return #
- □ May leave a detailed message

I consent to Evergreen Endoscopy Center, LLC discussing any or all of my personal medical information including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1. _____ Relationship: _____ Phone Number: _____

2. _____ Relationship: _____ Phone Number: _____

Responsibilities of the Patient

1. After discharge, **DO NOT DRIVE.** No alcohol, sleeping pills, and/or tranquilizers for 24 hours. Do not operate heavy machinery, go to work conduct important business, or sign legal documents until the day following your procedure.
2. All patients are responsible for notifying the facility of any change in their condition or change of insurance coverage prior to their procedure. All patients are responsible for assuring that the financial obligations for health care rendered are paid at the time of service, unless arrangements with the billing office were made prior to the date of service. This includes any charges incurred as a result of unpaid insurance premiums.
3. All patients are responsible to provide the facility, to the best of their knowledge, with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, medications, other pertinent data, insurance coverage, and the existence of advance directives.
4. All patients are responsible for accepting the consequences of their actions if they should refuse a treatment or procedure, if they do not follow instructions, or if they do not understand the instructions given them and do not ask for clarification by the doctor of their health care team member.
5. All patients are responsible for the disposition of their valuables as the facility does not assume this responsibility.
6. We request that you report any concerns you may have about your safety throughout the course of your care. Concerns can be voiced to the nurse administrator or physician at anytime without fear of impact on the quality of care you will receive. You may also communicate concerns to the following:
   - * **Department of Public Health Complaint Supervisor** ..... 1(860)509-7400
   - * **Medicare Complaints Hotline** ..... 1(888)973-0022
   - ***Joint Commission's Office of Quality Monitoring** ..... 1(800)994-6610 or ***complaint@jointcommission.org***

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Evergreen Endoscopy Center, LLC. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices. I acknowledge that I have read the Responsibilities of the Patient and understand what my responsibilities at the facility are and I will comply with them.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

□ Signed form received by: _____

□ Acknowledgement refused:

Efforts to obtain: _____