Garden State Endoscopy & Surgery Center

200 Sheffield St. Suite 101
Mountainside, NJ 07092
Tel: 908-241-8900 / Fax: 908-241-8933

SCA Health

Garden State Endoscopy and Surgery Center

affiliate of SCA and RWJ BH

ASC Conditions of Coverage Patient Attestation

Patient Name:_____ **Date of Procedure:**_____

I certify that I have received written documentation of the following items, in advance of the date and time of my scheduled procedure:

Patient Initials	
	1. PATIENTS' RIGHTS AND RESPONSIBILITIES
	2. NOTICE OF PATIENT RIGHTS UNDER THE "NO SURPRISE ACT"
	3. NOTICE OF PRIVACY PRACTICES
	4. INFORMATION ON ADVANCE DIRECTIVES
	5. DISCLOSURE OF PHYSICIAN OWNERSHIP
	6. NON-DISCRIMINATION AND LIMITED ENGLISH PROFICIENCY (LEP)
	7. PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY
	8. POLICY REGARDING JEWELRY AND RELEASE OF RESPONSIBILITY

Furthermore, I understand that this information is being provided for my benefit and by proceeding with the registration, I acknowledge that I reviewed the notices / disclosures above and all my questions regarding its content were answered to my satisfaction.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

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SCA Health

PATIENTS' RIGHTS AND RESPONSIBILITIES

Patients have rights and responsibilities as defined by the Patient's Bill of Rights and as supported by the State of New Jersey.

Legal Rights

- To treatment and medical services without discrimination based on age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment.
- To exercise all your constitutional, religious, civil, and legal rights.

Medical Care

- To receive the care and health services that the healthcare facility is required to provide.
- To receive an understandable explanation from your physician of your complete medical condition, recommended treatment, expected results, risks involved, and reasonable medical alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation will be given to your next of kin or guardian.
- To give informed written consent prior to the start of specified, non-emergency medical procedures or treatments only after your physician has explained to you, in words you understand, specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives.
- To refuse medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life threatening or the procedure is required by law.
- To be included in experimental research only if you give informed, written consent, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. You have the right to refuse to participate.

Pain Management

- To pain relief; to have appropriate assessment and ongoing reassessment of pain.
- To have appropriate management of pain taking into account personal, cultural, spiritual and/or ethnic beliefs.
- To receive information and education regarding pain, management of pain, potential limitations and potential side effects of pain treatment.

Communication & Information

- To be informed of the names and functions of all health care professionals providing you with personal care.
- Disclosure of physician financial interests or ownership in the Center.
- To change your provider if other qualified providers are available.
- To receive, as soon as possible, the services of a translator or interpreter if you need one to help you communicate with the facility's health care personnel: to receive communication services if you have vision, speech, hearing, or cognitive impairments in a manner that meet your needs.
- To be informed of provisions for after-hours and emergency care.
- To be informed of the names and functions of any outside health care and education institutions involved in your treatment. You may refuse to allow their participation.
- Advance directives, as required by state or federal law and regulations and if requested, official State advance directive forms.
- To receive, upon request, the facility's written policies and procedures regarding life-saving methods.
- To be advised in writing of the facility's rules regarding the conduct of patients and visitors.
- To receive a summary of your patient rights that includes the name and phone number of the healthcare facility staff member to whom you can ask questions or complain about any possible violation of your rights.
- Marketing or advertising regarding the competence and capabilities of the organization that is not misleading.
- To be informed of appropriate information regarding the absence of malpractice insurance coverage if applicable.
- The organization will inform the patient or surrogate decision maker about unanticipated outcomes of care, treatment, or services that relate to sentinel events.

Medical Records

- To have prompt access to the information in your medical record. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your record; To obtain a copy of your medical record, at a reasonable fee, within 30 days after written request to the facility.
- To access your record pursuant to the provisions of N.J. Admin. Code § 8:43G-15.3 of the Public Health Law.

Cost of Facility Care

- To receive a copy of the facility fees for services, eligibility for third party reimbursement and, when applicable, the availability of free or reduced cost care payment rates. If you request an itemized bill, the facility must provide one and answer any questions you may have. You have a right to appeal any changes.
- To be informed by the facility if part or your entire bill will not be covered by insurance. The facility is required to help you obtain any public assistance and private health care benefits to which you may be entitled.

Privacy & Confidentiality

- To have physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
- To be treated with courtesy, consideration, respect, and recognition of your dignity, individuality, and right to privacy, including, but not limited to auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
- To confidential treatment of information about you. Information in your records will not be released to anyone outside the healthcare facility without your approval, unless it is required by law. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

Freedom from Abuse & Restraints

- To freedom from verbal, physical, sexual and mental abuse.
- To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of you or others.

Transfers

- To be transferred to another facility only when you or your family has made the request, or in instances where the facility is unable to provide you with the care you need.
- To receive an advanced explanation from a physician of the reasons for your transfer and possible alternatives.

Personal Needs

- To be treated with courtesy, consideration, and respect for your dignity and individuality.
- To have access to storage space for private use. The facility has a system to safeguard your personal property.

Private Duty Nursing

- To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her care. A registered professional nurse so contracted shall adhere to healthcare facility policies and procedures so long as these requirements are the same for private duty and regularly employed nurses. The facility, upon request, shall provide the patient or designee with a list of local non-profit professional nursing association registries that refer nurses for private professional nursing care.

Discharge Planning

- To receive information and assistance from your attending physician and other health care providers if you need to arrange for continuing health care after your discharge from the facility.
- To receive sufficient time before discharge to arrange for continuing health care needs.
- To be informed by the healthcare facility about any appeal process to which you are entitled by law if you disagree with the facility's discharge plans.

Patient Guardian

- The patient's guardian, next of kin, or legally authorized responsible person has the right to exercise the rights delineated on the patient's behalf, to the extent permitted by law, if the patient has been adjudicated incompetent in accordance with the law, has designated a legal representative to act on his / her behalf or is a minor.

Patient Rights Notification

- You or your representative will be notified of your rights, both verbal and written, prior to the start of the procedure in a language and manner that you understand.

Patient Responsibilities: the patient has the responsibility to do the following:

- The patient is encouraged to ask any and all questions of the physician and staff in order that he/she may have a full knowledge of the procedure and aftercare.
- Follow the treatment plan prescribed by his/her provider and participate in his/her care.
- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Provide the organization with information about their expectations of and satisfaction with the organization.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as the other patients.

Patient Questions & Complaints

- To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice free from restraint, interference, coercion, discrimination, or reprisal.
- A complaint or grievance should be registered by contacting the center administrator and/or patient advocate through the State Department of Health or Medicare. All complaints and grievances will be logged with the specific issue reported, the date the report was received (verbal or written), the resolution and the date of closure. The center will respond in writing with notice of how the grievance has been addressed within 30 days.

CEO/Administrator: Ina L. Mendes
Garden State Endoscopy & Surgery Center
200 Sheffield Street, Suite 101
Mountainside, NJ 07092
Phone: (908) 241-8900
Email: ina.mendes@scasurgery.com

Medicare Beneficiary Ombudsman
1-800-MEDICARE 1-800-633-4227
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
P.O. Box 367, Trenton, NJ 08625-0367
Toll Free Hotline: 1-800-792-9770, Select #1
Fax: 609-943-4977 or 609-633-9060

Office of the Ombudsman for the Institutionalized Elderly
P.O. Box 852, Trenton, NJ 08625-0852
Toll Free Hotline: 1-877-582-6995
Fax: 609-943-3479
E-mail: PublicAdvocate@advocate.state.nj.us

For concerns about patient safety and quality of care that you feel have not been addressed appropriately by the center Administrator, you may contact:
The Accreditation Association for Ambulatory Health Care, 5250 Old Orchard Road Suite 200, Skokie, IL 60077,
E-mail: info@aaahc.org Tel: 847-853-6060 Fax: 847-853-9028

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SCA Health

Notice of Patient Rights under the "No Surprise Act"

Garden State Endoscopy & Surgery Center, LLC

Effective January 1, 2022 | Federal Law: 45 CFR §149.410–149.430

Your Rights Against Surprise Medical Bills

Under federal law, you have rights that protect you from unexpected medical bills. Please read this notice carefully.

What is the No Surprises Act?

The **No Surprises Act** is a federal law that protects patients from receiving unexpected "surprise" medical bills from out-of-network providers in certain situations — without your prior knowledge or consent.

Your Protections Include:

- **Emergency Services** — You cannot be billed more than your in-network cost-sharing amount (copays, coinsurance, and deductibles) for emergency services, regardless of whether the provider or facility is in-network.
- **Non-Emergency Services at an In-Network Facility** — You are protected from surprise bills for non-emergency services performed by out-of-network providers at this facility **unless** you are given proper notice and provide your written consent to be treated by an out-of-network provider.
- **Air Ambulance Services** — You are protected from surprise bills from out-of-network air ambulance providers.

Important Information About Our Facility

Garden State Endoscopy & Surgery Center participates with numerous insurance plans. However, please be aware that:

- Some **providers rendering services at this facility** (e.g., Anesthesiologists, Pathologists) may be **independently contracted** and may have different network participation status with your insurance plan.
- You have the right to **request a list of providers** who may be involved in your care and verify their network status with your insurance plan prior to your procedure.

Good Faith Estimate

You have the right to receive a **Good Faith Estimate** of expected charges before your scheduled service.

- ✓ If you are **uninsured or self-pay**, we are required to provide a Good Faith Estimate before your procedure
- ✓ If you have insurance, you may also request a Good Faith Estimate at any time.
- ✓ If your final bill exceeds your Good Faith Estimate by **more than $400**, you may have the right to dispute the charges.

To request a Good Faith Estimate, please speak with our **Registration/Billing Department** prior to or on the day of your procedure.

Your Right to Consent for Out-of-Network Care

- Except in **emergency situations**, you have the right to **refuse out-of-network care**.
- If out-of-network services are recommended for non-emergency care, you must be given written notice and must provide **voluntary written consent** before those services are rendered.
- Signing a consent form under **duress or without full understanding** does not constitute valid consent under this law.

How to File a Complaint

If you believe your rights under the No Surprises Act have been violated, you may file a complaint with:

U.S. Department of Health & Human Services (HHS) 📞 1-800-985-3059 🌐 www.cms.gov/nosurprises

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Questions?

Our **Insurance & Billing Representative** is available to assist you with any questions regarding your benefits, cost estimates, or provider network status.

📞 Please ask our front desk staff to connect you before or after registration.

By proceeding with registration, you acknowledge that you have received and reviewed this Notice of Patient Rights under the No Surprises Act.

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

For Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

I <Patient name>, hereby states that by signing this NOTICE, I agree and acknowledge the following:

1. The Notice of Privacy Practices ("Privacy Notice") for Garden State Endoscopy & Surgery Center (the "Center") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") by the Center. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The Center reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
2. I understand that, and consent to, the following appointment reminders that will be used by the Center:
3. A postcard mailed to me at the address provided by me; and/or
    a. Telephoning my home and leaving a message on my answering machine.
    b. Telephoning my cellphone or leaving a text message
    c. I understand that if I do not sign this Consent, evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Center will not treat me.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

NOTICE OF PRIVACY PRACTICES
Morris Avenue Endoscopy Center, LLC -dba
Garden State Endoscopy & Surgery Center

Effective Date: April 14, 2003, last revised August of 2025

YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Notice shall be applicable to the following entities:

- **[Garden State Endoscopy & Surgery Ctr.** (the "Center")
- **[Northern Valley Anesthesia Group]**
- **(Rahway Pathology, AGG Laboratory, Dianon & LabCorp; ADH Pathology)**

NOTE: Independent healthcare providers rendering care or treatment to you at the Center (e.g., surgeons, anesthesiologists, radiologists, pathologists) will also abide by the terms of this Notice with respect to your protected health information concerning care or treatment rendered to you at the Center. Accordingly, such independent providers may use and disclose protected health information about you concerning care or treatment rendered to you at the Center for the purposes discussed in this Notice (e.g., their own payment activities) and to the same extent as the Center may make such uses or disclosures under the terms of this Notice. Such independent providers may, however, have different policies or notices regarding their use and disclosure of medical information maintained by them concerning care or treatment rendered to you outside of the Center. Please note that such independent providers are neither employees nor agents of the Center, but are joined under this Notice for the convenience of explaining to you your rights relating to the privacy of protected health information about you concerning care or treatment rendered to you at the Center.

If you have any questions about this notice or need further information, please contact our Privacy Officer at **[Insert Privacy Officer's Phone Number]**. Written requests should be addressed to:

Garden State Endoscopy & Surgery Center
Attn: Privacy Officer
200 Sheffield St, Suite 101, Mountainside, NJ 07092

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION:

The privacy of your protected health information or "PHI" is important to us. This notice will tell you about the ways in which we may use and disclose your PHI. This notice describes your rights with respect to your PHI we collect and maintain and also describes certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

1. Maintain the privacy of your PHI;
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your PHI we collect and maintain;
3. Notify you if we discover a breach of any of your PHI that is not secured in accordance with federal guidelines; and
4. Follow the terms of the Notice of Privacy Practices that is currently in effect.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

You have the following rights with respect to your PHI:

5. **Right to Inspect and Copy:** You have the right to inspect and copy all or any part of your medical or health record, as provided by federal regulations. You may request and receive an electronic copy of your PHI if we maintain your PHI in an electronic health record.

To inspect and copy your PHI, you must submit your request in writing to our Privacy Officer at the address listed on the first page of this notice. If you request a copy of your PHI we may charge a reasonable, cost-based fee in accordance with state law for the costs associated with fulfilling your request.

We may deny your request under certain limited circumstances.

1. **Right to Amend:** You have the right to request that we amend your PHI or a medical or health record about you if you feel that health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to our Privacy Officer at the address listed on the first page of this notice, and must provide a reason that supports your request for an amendment. We may deny your request under certain limited circumstances.
2. **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your PHI we have made, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. If you request an accounting of disclosures of your PHI, the accounting may include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic health record. To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer at the address listed on the first page of this notice. Your request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
3. **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use and disclosure of your PHI. You also have the right to request a restriction or limitation on the disclosure of your PHI to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your PHI or that we not disclose information to your spouse about a surgery you had. If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third party payor for purposes of payment or health care operations. We are obligated by law to abide by such restriction. To request a restriction on the use and disclosure of your PHI, you must make your request in writing to our Privacy Officer at the address listed on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limitations to apply. We will notify you of our decision regarding the requested restriction. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.
4. **Right to Receive Confidential Communications:** You have the right to request that we communicate with you about your PHI in a certain way or have such communications addressed to a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to our Privacy Officer at the address listed on the first page of this notice. Your request must specify how or where you wish to be contacted.
5. **Right to a Paper Copy of** this **Notice:** You have the right to obtain a paper copy of this notice at any time upon request. At the time of first service rendered, we are required to provide you with a paper copy of this notice. To obtain a copy of this notice at any other time, please request it from our Privacy Officer at the address listed on the first page of this notice.
6. **Right to Revoke Authorization:** If you execute any authorization(s) for the use and disclosure of your PHI, you have the right to revoke such authorization(s), except to the extent that action has already been taken in reliance on such authorization.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

The following categories describe different ways that we may use and disclose your PHI without your authorization.

1. **For Treatment:** We may use your PHI to provide you with health care treatment or services. We may disclose your PHI to other doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. For example, another doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.
2. **For Payment:** We may use and disclose your PHI so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your visit to our practice so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
3. **For Health Care Operations:** We may use and disclose your PHI for operations of our practice. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. **For Research:** We may disclose your PHI for the purpose of research. We will only disclose your PHI for research purposes upon your express authorization or if the research protocol has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
5. **As Required By Law:** We may disclose your PHI when required to do so by federal, state, or local law.
6. **To Avert a Serious Threat to Health or Safety:** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
7. **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release your PHI as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.
8. **Workers' Compensation:** We may release your PHI as authorized by, and in compliance with, laws related to workers' compensation and similar programs established by law that provide benefits for work-related illnesses and injuries without regard to fault.
9. **Public Health Activities:** We may disclose your PHI for public health activities. These activities generally include the following:
    - to prevent or control disease, injury, or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify person or organization required to receive information on FDA-regulated products; and
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
1. **Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

2. **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
3. **Law Enforcement:** We may disclose your PHI to law enforcement officials for law enforcement purposes including the following:
    - in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
    - in response to a court order, subpoena, warrant, summons or similar process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime, if the victim agrees to disclose or under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at our facility; and
    - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
1. **Organ and Tissue Donation:** We may disclose your PHI to organizations involved in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue, for the purpose of facilitating organ and tissue donation where applicable.
2. **Abuse, Neglect and Domestic Violence:** We may disclose your PHI to an appropriate governmental authority if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
3. **Coroners, Health Examiners and Funeral Directors:** We may disclose your PHI to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors as necessary to carry out their duties.
4. **National Security and Intelligence Activities:** We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, or for the purpose of providing protective services to the President or foreign heads of state.
5. **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official. This release would be necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

EXAMPLES OF OTHER PERMISSIBLE OR REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

1. **Business Associates:** Some of our activities are provided on our behalf through contracts with business associates. Examples of when we may use a business associate include coding and claims submission performed by a third party billing company, consulting and quality assurance activities provided by an outside consultant, billing and coding audits performed by an outside auditor, and other legal and consulting services provided in response to billing and reimbursement issues which may arise from time to time. When we enter into contracts to obtain these services, we may need to disclose your PHI to our business associate so that the associate may perform the job which we have requested. To protect your PHI, however, we require our business associate to appropriately safeguard your information.
2. **Notification:** We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, close personal friend, or other person responsible for your care of your location and general condition. **We will not disclose your PHI to your family members, personal representative or close personal friends as described in this paragraph if you object to such disclosure. Please notify our Privacy Officer if you object to such disclosures.**
3. **Communication with family members:** Health professionals, including those employed by or under contract with us may disclose to a family member, other relative, close personal friend or any other person you identify, health information relative to that person's involvement in your care or payment related to your care, unless you object to the disclosure.
4. **Unlawful conduct:** Federal law allows for the release of your PHI to appropriate health oversight agencies, public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

WE MAY NOT USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE FOLLOWING PURPOSES WITHOUT YOUR AUTHORIZATION:

1. We must obtain an authorization from you to use or disclose psychotherapy notes unless it is for treatment, payment or health care operations or is required by law, permitted by health oversight activities, to a coroner or medical examiner, or to prevent a serious threat to health or safety.
2. We must obtain an authorization for any use or disclosure of your PHI for any marketing communications to you about a product or service that encourages you to use or purchase the product or service unless the communication is either (a) a face-to-face communication or; (b) a promotional gift of nominal value. However, we do not need to obtain an authorization from you to provide refill reminders, information regarding your course of treatment, case management or care coordination, to describe a health-related products or services that we provide, or to contact you in regard to treatment alternatives. We must notify you if the marketing involves financial remuneration.
3. We must obtain an authorization for any disclosure of your PHI which constitutes a sale of such PHI.
4. **We must obtain an authorization for all other uses and disclosures of your PHI not described in this notice.**

If you provide us with written authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change our privacy practices and any terms of this notice. If our privacy practices materially change, we will revise this notice and make copies of the revised notice available upon request. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future.

TO MAKE A COMPLAINT:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the number listed on the first page of this Notice. All complaints must be submitted in writing. **There will be no retaliation against you for filing a complaint.**

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

We will request that you sign a separate form acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, and date. This acknowledgement will be filed with your records.

Garden State Endoscopy & Surgery Center

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SCA Health

INFORMATION ON ADVANCE DIRECTIVES

In accordance with N.J. Stat. § 26:2H-53 we must inform you of the center policy on Advance Directives. Advance directives include but are not limited to a health care proxy, consent to a do-not-resuscitate (DNR) order recorded in your medical record and a living will.

Due to the fact that the Garden State Endoscopy & Surgery Center is an Ambulatory Surgery Center for the purpose of performing elective Endoscopy in a safe and uncomplicated manner, patients are expected to have an excellent outcome. If a patient should have a complication, the center staff will always attempt to resuscitate the patient and transfer that patient to a hospital in the event of deterioration.

If a patient should provide his/her Directive, a copy will be placed on the patient's medical record and transferred with the patient should a hospital transfer be ordered by his/her physician.

In order to assure that the community is served by this center, information concerning advance directives/Healthcare proxy and DNR orders is available at the center

Information on Advance Directives

Help Line: 800-658-8898 Multilingual Line: 877-658-8896
Email: caringinfo@nhpco.org Website: www.caringinfo.org

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology --- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention. Please be aware that some of the physicians performing procedures may have a direct financial ownership interest in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The **fee that we charge** for our services covers the **non-professional component** of your procedure also known as the "technical" or "facility" fee which includes the cost of operating this facility including equipment, staff, rent, supplies, etc.
2. You will also receive a separate bill from the physician's office for their professional services, anesthesia services, and possibly the laboratory for any pathology services.
3. The facility, anesthesia, laboratory, and physicians' professional office are all separate legal entities providing separate and distinct services. Some of these providers rendering services at this facility, such as: Northern Valley Anesthesia Group and Pathology vendors (Rahway Pathology, AGG Laboratory, Dianon & LabCorp; ADH Pathology) may be independently contracted and may have different network participation status with your insurance plan. You have the right to request a list of providers who may be involved in your care and verify their network status with your insurance plan prior to your procedure.
4. As a courtesy to our patient's, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process as long as we have the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.
5. We expect all known co-payments to be paid at the time of service or as required by the contract between the patient, the insurer, and our center. We reserve the right to collect co-pays, deductibles, and coinsurance upon notification by the insurer.
6. Some insurers require pre-certification, pre-authorization, or a written referral. It is the patient's responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. If your insurance denies the claim, or holds payment, you may be ultimately responsible for the balance.
7. If you have any questions related to the balance, please contact our Billing Office to discuss your account. Nonpayment will result in referral to an outside collection agency. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

Authorization to Release Information: I hereby authorize Garden State Endoscopy & Surgery Center, to release any and all information necessary for the billing and processing of the account for services rendered.

Assignment of Insurance Benefits: I hereby authorize payment to Garden State Endoscopy & Surgery Center insurance benefits, otherwise payable to me, for this service. Payment to Garden State Endoscopy & Surgery Center shall not exceed the balance due for services rendered.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that I am financially responsible to the center for charges not covered by this assignment.

Garden State Endoscopy & Surgery Center

200 Sheffield St. Suite 101
Mountainside, NJ 07092
Tel: 908-241-8900 / Fax: 908-241-8933

SCA Health

PHYSICIAN OWNERSHIP DISCLOSURE

This disclosure is being made by Garden State Endoscopy & Surgery Center, referred to in this document as "Your Physician - Ownership Disclosure".

Your physician participates in one or more quality and efficiency programs operated by your health insurer with respect to outpatient surgical services. These programs provide a financial incentive to participating physicians to achieve certain quality targets and to select cost effective, participating facilities for your care. The facility to which your physician will refer you, Garden State Endoscopy & Surgery Center, located at 200 Shefield Street, Suite 101, Mountainside, NJ 07092, is one such participating facility. You have the right to obtain the referred services or items at the facility of your choice, unless otherwise restricted by law. If you choose not to obtain the referred services or items at the facility identified above, you may request that your physician make an alternative referral.

Physicians who have OWNERSHIP at this Facility: **Dr. Amber Khan MD / Dr. Arun. Mathew MD / Dr. Daniel Bodek / Dr. Jefferey Shrensel MD / Dr. Kunal Grover MD / Dr. Michael Margolin MD / Dr. Michael Viksjo MD / Dr. Patrick Tempera MD / Dr. Prakriti Merchant MD / Dr. Rajesh Dhirmalani MD / Dr. Ricardo Rodriguez MD / Dr. Robert Greenblatt MD / Dr. Ramon Ledon / Dr. Michael Rosen**

NOTICE OF NONDISCRIMINATION

NOTICE OF SECTION 1557 IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

Garden State Endoscopy & Surgery Center complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for people with disabilities.

If you need these services, call the toll-free number 908-241-8900

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Facility CEO: Ina Mendes
Garden State Endoscopy & Surgery Center
200 Sheffield Street, Suite 101
Mountainside, NJ 07092
Phone: (908) 241-8900
Email: ina.mendes@scasurgery.com

If you need help filing a complaint, call the toll-free number 908-241-8900.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at: https://gardenstateendoscopy.com/ and is Posted at the location of the facility: 200 Sheffield Street, Suite 101 Mountainside NJ 07092

Garden State Endoscopy & Surgery Center

200 Sheffield St. Suite 101
Mountainside, NJ 07092
Tel: 908-241-8900 / Fax: 908-241-8933

SCA Health

Policy Regarding Jewelry and Release of Responsibility

Garden State Endoscopy & Surgery Center, LLC

I, _____ ("Patient"), have been informed and am aware that I am responsible for all jewelry, including but not limited to rings, earrings, necklaces, piercings, bracelets, and watches ("Jewelry"), prior to performance of my surgery or procedure at the Garden State Endoscopy & Surgery Center, LLC. If the physician(s) and/or other medical staff involved in such surgery or procedure may have to remove my Jewelry, by whatever means is necessary, including but not limited to, cutting the Jewelry, or otherwise damaging the Jewelry beyond repair.

Patient (and his or her family members, guardians, estate, attorneys or anyone claiming rights on behalf of the Patient) (hereinafter the "Patient Parties"), hereby release and absolutely and forever discharge the Garden State Endoscopy & Surgery Center, LLC, (and all of its respective members, officers, employees, managers, agents, successors, assigns, executors, legatees, devisees, predecessors in interest, successors in interest and attorneys) (hereinafter the "Center Parties") from all claims, rights, demands, representations, expenses, attorneys' fees, costs and causes of action of every kind and nature whether known or unknown, anticipated or unanticipated, suspected or unsuspected, whether at law or in equity, which the Patient Parties may have or claim to have against the Center Parties related to the Patient's Jewelry, responsibility of, or failure to remove, such Jewelry during any surgery or procedure, or injury to the Patient resulting from the removal of such Jewelry.