

Hanover Endoscopy Center
PLEASE COMPLETE ALL INFORMATION

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

PATIENT: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ SOCIAL SECURITY # _____
CITY _____ HOME PHONE#: _____
STATE _____ ZIP CODE: _____ WORK PHONE: _____
MOBILE/CELL PHONE #: _____ EMAIL ADDRESS: _____
MARITAL STATUS : Please circle : M S D W FEMALE _____ MALE _____
REFERRING/FAMILY PHYSICIAN: _____
DO YOU HAVE A LIVING WILL? YES NO WOULD YOU LIKE INFORMATION? YES NO

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE _____
MEMBER# _____ GROUP# _____
INSURED EMPLOYER: _____ EMPLOYER PHONE #: _____
NAME OF INSURED _____ INSURED SOCIAL SECURITY _____
INSURED DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE _____
MEMBER # _____ GROUP# _____
INSURED EMPLOYER: _____ EMPLOYER PHONE #: _____
NAME OF INSURED: _____ INSURED SOCIAL SECURITY : _____
INSURED DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT INFORMATION

CONTACT NAME: _____ PHONE #: _____
RELATIONSHIP: _____ ALTERNATE PHONE #: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that I have provided accurate insurance information for services rendered at Hanover Endoscopy Center. I agree that a photocopy of this form may be used in place of the original.

Signed (Patient or Representative)

Date

PLEASE COMPLETE & BRING WITH YOU TO HANOVER ENDOSCOPY CENTER ON DATE OF APPOINTMENT.

Rights and Respect for Property and Person

The patient has the right to:

Exercise his or her rights without being subjected to discrimination or reprisal

Voice grievance regarding treatment or care that is or fails to be furnished

Be fully informed about a treatment or procedure and the expected outcome before it is performed

Confidentiality of personal medical information

Privacy and Safety

The patient has the right to:

Personal privacy

Receive care in a safe setting

Be free from all forms of abuse or harassment

Advance Directives

You have the right to information on the Center's policy regarding Advance Directives.

Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

If you request, an official state Advance Directive Form will be provided to you.

Submission and Investigation of Grievances: You have

the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

The following are the names and/or agencies you may contact:

ANGELA NOVACK RN, CENTER DIRECTOR
FLORHAM PARK ENDOSCOPY CENTER
HANOVER ENDOSCOPY CENTER

You may contact your state representative to report a complaint;

www.cdc.gov/mmwr/about.html

DEPT. OF HEALTH AND SENIOR SERVICES
<http://www.nj.gov/health/facilities/hotline.shtml>

Complaint hotline-1-800-792-9770

Sites for address and phone numbers of regulatory agencies: **Medicare Ombudsman website**

www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

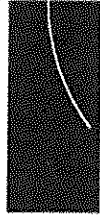
Office of the Inspector General: <http://oig.hhs.gov>

Physician Financial Interest and Ownership: The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

Signature of Patient or Patient Legal Representative _____

Date _____



Patient Rights and Notification of Physician Ownership

Florham Park Endoscopy Center
195 Columbia Turnpike
Florham Park, NJ 07932
973-410-1800

Hanover Endoscopy Center
91S-Jefferson Rd
Suite 300
Whippany, NJ 07981
973-929-6800

**PLEASE BRING THIS FORM WITH YOU
ON THE DAY OF YOUR PROCEDURE**

AS A PATIENT OF THE FLORHAM PARK /

HANOVER ENDOSCOPY CENTERS, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF THE PROCEDURE.

PATIENT'S BILL OF RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

PATIENT RIGHTS:

- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.

- To be free from mental and physical abuse, free from exploitation, & free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

- Leave the facility even against the advice of his/her physician.

- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.

- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge for the facility.

- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

- Know which facility rules and policies apply to his/her conduct while a patient.

- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.

- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his or her patient record.

- Examine and receive an explanation of his/her bill regardless of source of payment.

- To appropriate assessment and management of pain.

If you need a translator:

If you will need a translator, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.