WELCOME TO THE RWJ ENDOSURGICAL CENTER, LLC

Our center is owned and operated by:

Mitchell Ferges, MD
Satya Kastuar, MD
Ira Merkel, MD
Alexander Rapisarda, MD
Allan Plumser, MD
Jose Costa, MD
Neil Sinha, MD

Our center is a freestanding Medicare Certified Facility in Middlesex County.

Directions

GPS USERS ONLY

Please enter *213 Summerhill Road* as your destination

From South of East Brunswick traveling on Route 18 North: After passing through Old Bridge look for signs for Rues Lane. Take the jug handle to the right and cross back over Route 18 onto Rues Lane. *Follow Rues Lane through the first traffic light (Summerhill Road). Make your first right after the light turning into the driveway behind our building. The Center is immediately on your right.

From North of East Brunswick traveling on Route 18 South: Take Route18 South about 5 miles past the New Jersey Turnpike. Turn right (just past the Brunswick Square Mall and Olive Garden) onto Rues Lane. *Follow directions above.

Revised 7/2015-Aleman

RWJ ENDOSURGICAL CENTER, LLC

800 Ryders Lane
East Brunswick, NJ 08816

GPS ADDRESS:
213 Summerhill Rd.
East Brunswick, NJ 08816

Tel: (732) 432-6880
Fax: (732) 432-6885

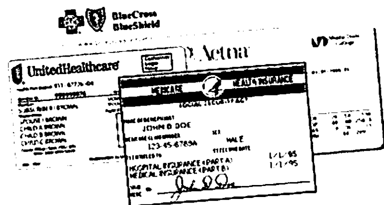
Monday-Friday
7:00am-3:00pm

What services do we offer?

At the RWJ Endosurgical Center we provide our patients with endoscopic procedures such as gastroscopy, esophageal dilatation, colonoscopy and polypectomy which visualize and treat conditions of the esophagus, stomach or small and large intestines without the need or inconvenience of a hospital stay. We also provide various Pain Management services.

We offer patients:

- A more convenient, comfortable and safe alternative for their gastroenterology and Pain Management needs
- A shorter and more stable recovery period as a result of fast-acting anesthetics and new procedures
- Ambulance transfer services to RWJ in an unlikely event of an emergency
- On-site parking with handicapped access
- Licensed, professional, courteous and caring staff
- Bilingual staff



Meeting Your Insurance Needs

We understand the important role health insurance plays in our patient's medical care. In addition to Medicare we accept most major medical insurance plans. If you have a question, or concern about your insurance coverage, please contact your doctor's office prior to your procedure.

Advanced Endosurgery Care & Pain Management

The RWJ Endosurgical Center, LLC is a freestanding, physician owned, patient-oriented ambulatory surgical center. Since its opening in March 2000, the RWJ Endosurgical Center, LLC has impeccable success rate; currently performing over 6,000 procedures per year.

At the Center we utilize today's most advanced medical technology and equipment to provide you with the highest quality of care.

Our 6,800 square foot state-of-the-art Ambulatory Surgery Center offers fully equipped operating rooms, an admitting room, a post recovery room, a spacious waiting room, and a full array of amenities to make every patient feel comfortable and at ease throughout their visit.

Our patients undergo intravenous conscious sedation and monitoring just as they would within a hospital or medical center setting. Our knowledgeable and professional staff includes: highly trained physicians, registered nurses and medical endoscopy technicians. They are trained in the latest surgical techniques and medical care. Our common goal is to provide a comfortable and caring environment for our patients.

We strive to achieve and maintain optimal standards in providing patient focused quality care. If you have any concerns about patient care or safety at the surgery center, you can contact the facility administrator:

Carol Poppiti: (732) 432-6880

Revised 7/2015-Aleman

Preparing for your procedure

DAY BEFORE YOUR PROCEDURE

1. Follow your physician's instructions, if given, regarding your preparation for the procedure.
2. **Do not** drink or eat anything after midnight on the night prior to your procedure, unless instructed otherwise.
3. You must arrange to have someone drive you home after your procedure unless no anesthetic is required for your procedure. The medications you will receive have sedative effects that slow your reflexes, so it is unsafe to drive after your procedure.
4. A member of our staff will call you the day before your procedure to give you the time of arrival and any other pertinent information.

DAY OF YOUR PROCEDURE

1. Bring your completed paper work, driver's license or a different form of picture id, and insurance card(s). All insurance authorizations, and/or referrals must be obtained prior to performing the procedure otherwise you will be financially responsible.
2. Bring a list of your current medications and copy of Power of Attorney – if applicable.
3. Leave **all jewelry** and valuables at home.
4. Do not wear any lotion or perfume.
5. Wear comfortable clothing that is easy to take off and put on.
6. Arrive promptly on the day of your procedure as indicated during your pre-op phone call.
7. Sign in and register with our receptionist. You will be asked to electronically sign the consent form given to you by the physician's office to authorize the doctor to perform the procedure.
8. Your family/driver may wait in our waiting room or may leave after providing us with a contact phone number.
9. After your procedure, you will be monitored in our Recovery Room and given refreshments.
10. After your recovery, your doctor will talk to you and the nurses will give you verbal and written discharge instructions.

DAY AFTER YOUR PROCEDURE

1. You will receive a follow-up call from one of our nursing staff to discuss any concerns you may have.

Please call your doctor's office if you have any discomfort or concerns.

RWJ-Endosurgical Center

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Procedure Date:___________________________

Dear Patient:

We look forward to the opportunity to provide you with the best possible care during your short stay at our ambulatory surgery center. The enclosed information will answer some of your questions.

You will be called the day before your scheduled procedure by the surgery center to be given your arrival time. This time may differ from the time given to you by your physician's office, due to schedule changes.

Your insurance company may receive as many as four bills for your stay with us. They will be billed for your doctor's services, our services, anesthesiology services, and in some cases laboratory services. We emphasize that as a medical care provider, our relationship is with you, not your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (60 days), you will be expected to follow-up with your insurance company. You are ultimately responsible for any charges your insurance does not pay and to ensure that all requirements are complete prior to treatment.

All co-payments and co-insurance (if applicable) are due in full at the time of service. You may be required to fill out a Credit Card Authorization Form to secure payment for unmet deductibles. Fees quoted to you by your physician's office may change depending upon procedure findings. For your convenience, we accept cash, check and all major credit cards. Options are also available to apply for Care Credit at CareCredit.com.

Please read and fill out the enclosed forms and bring them with you along with your insurance card, any referrals you may need, a photo ID, a list of medications you are taking (if applicable) and any financial responsibility. When you arrive at the center the day of your procedure you will be asked to electronically sign the consent that is included in this packet.

All women of child-bearing age will be required to leave a urine sample for pregnancy testing.

Directions are included in our brochure. **You must have a ride home after your procedure (a taxi is not adequate).** Your driver is welcome to relax in our waiting room. An average stay at the center is 1 ½ to 2 ½ hours.

Please feel free to call the surgery center or your doctor's office if you have any questions.

Thank you.

Rev. 5/11/16

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PATIENT INFORMATION

Name: ____
Last First MI

SS #: ______-______-______ Birth Date: ____/____/____ Age: _____

Sex: [ ] Male [ ] Female

Marital Status : [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Domestic Partner

Phone: (________) ____________________ Work/Cell Phone: (________) ____________________
Area Code Area Code

Address: ____
Street City State Zip

Emergency Contact Person: ____
Name Phone Relationship

Patient's Employer: ______________________________ Occupation: ____________________

Employer's Address: ____
Street City State Zip

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

REGISTRATION

Patients are to fill out sections I and II. Do not write in any of the shaded areas.

Procedure: ____________	PT arrival time: ____________	Responsible companion: ____________
Physician: ____________	Scheduled time: ____________	[ ] waiting [ ] to be called at: ________ [ ] will return at: ________
		Reason for procedure per PT: ____________

Do we have permission to speak to your Responsible Adult Companion regarding your condition? [ ] YES[ ] NO

I. General Medical Information

AGE: ________ HEIGHT: ________ WEIGHT: ________

PRESENT MEDICATIONS AND DOSAGES: ____________

ALLERGIES TO MEDICATIONS: ____________

LATEX ALLERGIES TO RUBBER GLOVES / BANDAIDS: ____________

LIST ANY PREVIOUS SURGERIES: ____________

FEMALES ONLY: ARE YOU PREGNANT, PLANNING A PREGNANCY, OR NURSING A CHILD? ☐ YES ☐ NO LAST MENSTRUAL PERIOD: ______

DO YOU SMOKE? ☐ NO ☐ YES ☐ CIGARETTES ☐ PIPE ☐ CIGARS HOW MUCH PER DAY? ________

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, CIRCLE ONE: RARELY OCCASIONALLY DAILY

II. Personal Medical History

	YES	NO	NURSING COMMENTS
HEART DISEASE	[ ]	[ ]	
PACEMAKER / DEFIB.	[ ]	[ ]	
HEART ATTACK	[ ]	[ ]	
CHEST PAIN / PRESSURE	[ ]	[ ]	
HIGH BLOOD PRESSURE	[ ]	[ ]	
ASTHMA / EMPHYSEMA	[ ]	[ ]	
T.B.	[ ]	[ ]	
SLEEP APNEA	[ ]	[ ]	
KIDNEY DISEASE	[ ]	[ ]	
PROSTATE PROBLEMS	[ ]	[ ]	
DIABETES	[ ]	[ ]	
LIVER DISEASE	[ ]	[ ]	
HEPATITIS / HIV	[ ]	[ ]	
CANCER	[ ]	[ ]	
STROKES / SEIZURES	[ ]	[ ]	
EPILEPSY [ ]		[ ]	
BLEEDING DISORDER	[ ]	[ ]	
GLAUCOMA	[ ]	[ ]	
CATARACTS	[ ]	[ ]	
THYROID DISEASE	[ ]	[ ]	
PROSTHESIS / IMPLANTS	[ ]	[ ]	

Nurses Notes: ____________

III. Admitting

VITAL SIGNS:

T: ______ P: ______ R: ______ R.A. SAT: ______ % BP: ______

ECG NSR: ____________OTHER: ________

Skin: [ ] Warm [ ] Cool [ ] Dry [ ] Moist

Color: ____________

Mental Status:[ ] Alert [ ] Oriented [ ] Confused

Other: ____________

Abdomen: [ ] Soft [ ] Firm [ ] Distended [ ] Non-distended

Lungs: [ ] CTA [ ] Other________

Comfort: Pain: None Location: ____________

Severity (scale 1-10): ____________

PRE-PROCEDURE CHECKLIST:	**YES**	**NO**
Pre-procedure teaching done / Patient verbalizes understanding	[ ]	[ ]
Identaband on and information verified	[ ]	[ ]
Consent signed / No further questions	[ ]	[ ]
Prep Taken: ____________	[ ]	[ ]
NPO since: ____________	[ ]	[ ]
H&P		
Removal of dentures:		
[ ] upper [ ] full [ ] partial [ ] N/A	[ ]	[ ]
[ ] lower [ ] full [ ] partial [ ] N/A	[ ]	[ ]
Loose Teeth	[ ]	[ ]
Glasses/contact lens [ ] N/A	[ ]	[ ]
Ring/Watch/Necklace Bracelet/Chain/Earring	[ ]	[ ]
Hearing Aid [ ] Right [ ] Left [ ] N/A	[ ]	[ ]

IV / Saline Lock Type: ____________ Attempts: ________

Started with: ____________ Site: ____________ Start Time: ________

RN Signature ____________ Date ________

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PATIENT LABEL

PRE-PROCEDURE NURSING RECORD

Revised 5/2013

RWJ-ENDOSURGICAL CENTER
800 Ryders Lane
East Brunswick, NJ 08816
Tel: (732)432-6880 Fax: (732)432-6885

Patient Name:
Date of Birth:
Procedure Date:
Physician:
Procedure

Upper GI endoscopy, Colonoscopy

Explanation of Procedure (in layman's terms)

Visualization of the digestive tract with flexible lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for, and the possible risk, of these procedures. At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If any abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with solution which can be sent for special study of abnormal cells (cytology). Small growths may be removed (polypectomy) for microscopic examination. Abnormal blood vessels may be injected with chemicals.

Principle Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, all of the below complications are possible. Your physician will discuss their frequency with you, with particular reference to your own indications for gastrointestinal endoscopy.

YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR PROCEDURE.

- Perforations: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, hospital admission and surgery may be required.
- Bleeding: Bleeding, if it occurs, is usually a complication of a biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation but may require transfusions, endoscopic cautery or possible surgery.
- Risks of IV Conscious Sedation: For your safety your heart rate will be monitored. Cardiac arrhythmia may occur and a slightly longer recovery may be necessary. Possible complications of IV Conscious Sedation include, but are not limited to: respiratory depression and cardiac arrhythmia.
- Medication Phlebitis: Medications used for sedation may irritate the vein in which they are injected. This causes red, painful swelling of the vein and surrounding tissue. Discomfort in the area may persist for several weeks.
- Other Risks: Include but are not limited to drug reactions and complications from other diseases you may already have. Instrument failure and death are extremely rare, but remain remote possibilities.

YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, no test is 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or a mis-diagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

Insurance Authorization and Assignment

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to the RWJ- Endosurgical Center for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to my self or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Laboratory Testing

During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New Jersey now requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Endosurgical Center of Central NJ to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you.

Patients' Rights and Privacy Practices

I have been offered a copy and an explanation of the NJ Patients' Bill of Rights with grievance process.
I have been offered a copy and an explanation of the HIPAA Notice of Privacy Practices.
I have been made aware of physician ownership.

INFORMED CONSENT

Diagnostic/Therapeutic Procedures

- EGD (Esophagogastroduodenoscopy): An examination of the esophagus, stomach and duodenum.
- Small Bowel Endoscopy: An examination of the small bowel.
- Colonoscopy: Examination of all of the major portions of the colon.
- Flexible Sigmoidoscopy: Examination of the anus, rectum, and last part of the colon.
- Polypectomy: The removal of growths (polyps) in the digestive tract using a wire loop or forceps and electric cauterizing) current.
- Cauterization or Injection Therapy: Use of heat or chemical agents applied to a bleeding source.
- Dilation: Dilating tubes or balloons are used to stretch narrow areas of the digestive tract.
- PEG/PEJ (Percutaneous Endoscopic Gastrostomy or Jejunostomy): Placement or Removal
- Paracentesis: Removal of intra-abdominal fluid via a needle or catheter.

My signature below indicates an understanding of the following:

This is to verify that I was instructed not to eat, drink, or take any medication (unless specified by my physician) after midnight last night and that I have followed those instructions.

I have made arrangements to have an adult drive me home. I understand I will not be released by myself or with a minor. I do not plan to drive a car or even take a cab alone. (PATIENTS RECEIVING IV SEDATION ONLY)

If my surgeon or a member of the center staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood for the human immunodeficiency virus (HIV) and hepatitis.

I certify that I understand the information regarding these procedures and that I have been fully informed of the risks and possible complications thereof. I consent to the taking of biopsies and reproduction of any photographs taken in the course of this procedure for professional purposes. I consent to the administration of intravenous conscious sedation by or under the direction and supervision of an anesthesiologist or _____, MD .

I hereby authorize and permit_________, MD to perform upon myself the above initialized procedures. If any unforeseen condition arises during the procedure calling for additional procedures or medications (including anesthesia and blood transfusions), admission to the hospital, or surgery, I further request and authorize him/her to do whatever he/she deems advisable in my interest. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

Advanced Directive

Advance directives or "living wills" are recognized in the state of New Jersey as legal documents which offer evidence of an individual's medical treatment preferences. The United States Supreme Court affirmed, in its Cruzan decision, that an individual's personal wishes are then subjected to constitutional protection. I understand that I am not required to have an Advanced Directive in order to receive medical treatment in this health care facility. I further understand that it is the policy of this facility to resuscitate patients that require resuscitation in order to maintain their vital functions. In case of an emergency I understand that I may be transferred to a local hospital for treatment.

Valuables Release

I agree that the RWJ- Endosurgical Center is not responsible for any valuables that I have elected to bring.

<PatientSig>
<PhysicianSig>
<SignatureWitness>
<SignatureAnesthesia>

A Patient's Bill of Rights and Responsibilities

Each patient receiving care in an ambulatory care facility shall have the following rights and responsibilities:

1. Each patient has the right to be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify the patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. Each patient has the right to be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. Each patient has the right to be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. Each patient has the right to receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and unexpected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information of the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. Each patient has the right to participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. Each patient has the right to be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with the law, rule, and regulation. The patient may refuse to participate in experimental research including the investigation of new drugs and medical devices;
7. Each patient has the right 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 either individually or as a group and free from restraint, interference, coercion, discrimination, or reprisal;
8. Each patient has the right to be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or Patient's Rights or others from injury. Drugs and other medications shall not be used for discipline of patients or of convenience of facility personnel;
9. Each patient has the right to confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of such information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. Each patient has the right to be treated with courtesy, consideration, respect, and recognition of the patient's 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;
11. Each patient has the right to not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules'
12. Each patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and
13. Each patient has the right to not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility;
14. It is the responsibility of the Center to know and understand the patient's bill of rights and responsibilities.
15. Patient will receive a signed copy of the "Patient's Bill of Rights and Responsibilities" and the original document will be maintained in Medical Records.
16. Since effective treatment depends in part on patient's history, the Center expects the patients or patient's family to provide information about past illnesses, hospitalizations, medications, and other pertinent matters.
17. The Center expects the patient will ask questions about directions or procedures they don't understand
18. The Center expects the patient to be considerate of other patients and staff in regard to making noise, smoking, and number of visitors in the patient areas. The patient is also expected to respect the property of the Center and of other persons.
19. To help the patient's physicians and the Center staff care for the patient, the patients are expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and Center staff.
20. The patient assumes financial responsibility for all services either through their insurance or by paying at the time of service.
21. The patients are expected to follow all safety regulations that they are told or read about.
22. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions.

23. Except for emergencies, the practitioner shall obtain the necessary informed, written consent prior to the start of specified non-emergency procedures or treatments only after a physician has explained-in terms the patient understands-specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. (N.J.A.C. 8:43G-4.1(a)7.) Informed consent is required by the State of New Jersey. (N.J.A.C. 8:43A-13.3(a)16).
24. A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as part of a medical care research program or donor program, and the patient, or responsible person, may refuse to continue in a program to which he has previously given consent.
25. The patient who does not speak English shall have access, where possible, to an interpreter.
26. The patient can choose to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
27. As a Person with Pain, You Have:
    a. The right to have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, or pharmacists and other healthcare professionals.
    b. The right to have your pain thoroughly assessed and promptly treated.
    c. The right to be informed by your doctor about what may be causing your pain, possible treatments, and the benefits, risks and costs of each.
    d. The right to participate in decisions about how to manage your pain.
    e. The right to have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
    f. The right to be referred to a pain specialist if your pain persists.
    g. The right to get clear and prompt answers to your questions, to take time to make decisions, and to refuse a particular type of treatment if you choose.

The administrator shall provide all patients and/or their families upon request with the name, address, and telephone number of the following offices where complaints may be logged:

Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN367
Trenton, New Jersey 08625-0367
Telephone: (800) 792-9770
http://www.state.nj.us/health/healthfacilities
And
State of New Jersey
Office of Ombudsman for Medicare Beneficiaries
CN808
Trenton, New Jersey 08625-0808
Telephone: (877) 582-6995
http://www.medicare.gov/Ombudsman/activities.asp

The Joint Commission
E-mail: complaint@jointcommission.org
Telephone (630) 792 5800
Mail: Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Administrator/ Director of Nursing
Carol Poppiti, RN

732-432-6880

NOTICE OF PRIVACY PRACTICES

RWJ Endosurgical Center

Effective Date: September 23, 2013

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

If you have any questions about this notice, please contact our Administrator at 732-432-6880. Written requests should be addressed to:

RWJ Endosurgical Center
Attn: Administrator
800 Ryders Lane
East Brunswick, NJ 08816

WHO WILL FOLLOW THIS NOTICE:

- RWJ Endosurgical Center

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you. This notice also describes your rights to get access to the health information we keep about you and describes certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the Notice of Privacy Practices that is currently in effect.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

1. **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 protected health information, or "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 Administrator 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 to inspect and copy your PHI in certain limited circumstances.
2. **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 Administrator at the address listed on the first page of this notice, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless you provide a reasonable basis for us to believe that the person or entity that created the information is no longer available to make the requested amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your PHI or other medical or health records about you will be disclosed to those with whom we disclose information.

3. **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 Administrator at the address listed on the first page of this notice. Your request must state a time period which may not be longer than six 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. We will, to the extent possible, mail you a list of disclosures in paper form within 60 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; such date will not be later than a total of 90 days from the date you made the request.
4. **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.
   We are not required to agree to your request for restrictions, except if you pay for a service entirely out-of-pocket. 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 Administrator 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; for example, use of any PHI by a specified nurse, or disclosure of specified surgery to your spouse. 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.
5. **Right to Receive Confidential Communications:** You have the right to request that we communicate with you about your health information 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 Administrator at the address listed on the first page of this notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. **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 Administrator at the address listed on the first page of this notice.
7. **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 HEALTH INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION:

The following categories describe different ways that we use and disclose your PHI without your authorization. For each category of such uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

1. **For Treatment:** We may use your PHI to provide you with health care treatment of services. We may disclose your PHI to provide you with health care treatment or services. We may disclose your PHI to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our surgery center, at the hospital if you are hospitalized under our supervision, or at a doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
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 surgery center 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 surgery center. These uses and disclosures are necessary to run our surgery center and make sure that all of our patients receive quality care. 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. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.
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 and only 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. **For Quality Improvement:** We may use your PHI as a tool for quality assurance and continuous quality improvement.

6. **As Required By Law:** We may disclose your PHI when required to do so by federal, state, or local law.
7. **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. Any disclosure, however, would only be to someone able to help prevent the threat.
8. **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.
9. **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.
10. **Public Health Risks:** 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;
    - 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; and
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
11. **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.
12. **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.
13. **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:
        - Name and address
        - Date of birth or place of birth;
        - Social security number;
        - Blood type or Rh factor;
        - Type of injury;
        - Date and time of treatment and/or death, if applicable; and
        - A description of distinguishing physical characteristics.

- 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.

14. **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.
15. **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.
16. **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.
17. **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.
18. **Protective Services for the President and Others:** We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
19. **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 (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

1. **Business Associates:** Some activities of RWJ Endosurgical Center 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. RWJ Endosurgical Center **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 the Administrator at the number listed on the first page of this notice if you object to such disclosures.**

3. **Communication with family members:** Health professionals, including those employed by or under contract with RWJ Endosurgical Center 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. 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.

Any use or disclosure of your PHI that is not described in this notice will be made only with your written authorization.

WE MAY NOT USE OR DISCLOSE YOUR 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. If the marketing involves financial remuneration, we must notify you if such remuneration is involved.

3. We must obtain an authorization for any disclosure of your PHI which constitutes a sale of such PHI.

OUR RESPONSIBILITIES:

1. We are required by law to maintain the privacy of your PHI, to provide you with this notice as to our legal duties and privacy practices with respect to your PHI we maintain and collect, and notify you if we discover a breach of any of your PHI that is not secured in accordance with federal guidelines.
2. We are required by law to abide by the terms of this notice as it is currently in effect.

CHANGES TO THIS NOTICE:

We reserve the right to change our privacy practices for all PHI that we collect or maintain and any terms of this notice. If our privacy practices materially change, we will revise this notice and provide you with a copy of the revised notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain at the top of the first page, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

FOR MORE INFORMATION OR 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 Department of Health and Human Services. To file a complaint with us, contact our Administrator. All complaints must be submitted in writing. **There will be no retaliation against you for filing a complaint.**

If you have any questions or would like additional information, or if you wish to file a complaint with us regarding our use and disclosure of your PHI, you may contact our Administrator at 732-432-6880.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Other uses and disclosures of your PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

We will request that you sign a separate form or notice 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of RWJ Endosurgical Center. The Notice of Privacy Practices provides information about how we may use and disclose my protected health information.

I acknowledge receipt of the Notice of Privacy Practices of RWJ Endosurgical Center.

____ Date:__________________
(patient/parent/conservator/guardian)

FOR RWJ Endosurgical Center USE ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

____
____
____
____
____

Signature of RWJ Endosurgical Center representative:_________________________
Date:__________

Exhibit C