Kievers L.
Cunningham, MD
Medical Director

2631 Forest Dr
Columbia, SC 29204
Phone: 803-254-8449
Fax: 803-254-8984

Dear Patient,

We at **Sandhills Endoscopy Center** look forward to the opportunity to serve you for your upcoming test. This information packet is provided in preparation for your examination. This packet includes:

- Authorization to Release Patient Information
- Patient Registration Form
- Patient's Current Medication List
- Patient Surgery Center Admission
- Patient Privacy Statement
- Patient Rights and Responsibilities
- Patient Grievance Policy
- Advance Directives Policy

Please sign and date the first four forms in the packet.

Our Medical Records Release form only needs your signature at this time. Our staff will fill all applicable fields for you if any records need to be released.

You can call the office to inquire about the amount due at the time of your procedure. This amount is an estimate based on your insurance carrier benefits. These benefits include coinsurance, co-pay and any secondary insurance you may have. Based on your yearly benefits, you may also have a deductible that may or may not have been met at the time of your appointment with us. However, you may have had some other tests, which have not yet reached your insurance company that will apply towards your deductible. We will attempt to answer any questions you may have regarding your deductible when we contact you by phone.

Please note that if you are unable to keep your appointment, we require a **72-hour** notice or **3 business days**. If the appointment is not cancelled prior to this time, there will be a **$50** cancellation fee. Additionally, there is a **$100 fee if you do not show** for the appointment and fail to inform us that you are unable to keep the appointment.

You can pay for your procedure by cash, check, money order, or credit card (American Express, Discover, MasterCard or Visa).

Once we discuss the amount due on your date of service, we expect you to pay your full responsibility at the time of your test unless you make arrangements in advance. If arrangements have not been made prior to your test, then you may need to be rescheduled.

Please be sure to bring all of your insurance cards and your photo ID to your appointment along with the attached paperwork

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME: MAIDEN/PRIOR NAME

DATE OF BIRTH:_____ CURRENT PHONE #

I prefer to have these records: ❑Picked up at Sandhills Endoscopy Center ❑Faxed ❑Mailed

I hereby authorize and request the release of the following information:

❑ Patient Information for visit date(s) of to

❑ Billing Statements for visit date(s) of to

❑ Specific Lab/X-Ray/Report:

WE WILL NOT SEND RECORDS TO THIRD PARTIES WITHOUT A PROPER AUTHORIZATION FROM THAT THIRD PARTY.

Purpose for release of information:

This authorization expires on: (If no date is specified, this authorization will expire in 6 months

FROM:
Sandhills Endoscopy Center
2631 Forest Drive
Columbia, SC 29204

TO:Name:_____
Address _____
City, State, Zip _____
Fax _____ **Phone** _____

If you **do not** wish **to release records containing** information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and or alcohol abuse, mental illness or psychiatric treatment, please initial here_.
Unless initiated here this information is deemed permissible to release.

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and know that I do not need to sign to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimiles of this Authorization shall be considered to be the same as a signed original document.

This section to be completed by Sandhills Endoscopy Center

The patient requests that medical records be released from:

Name of Doctor/Practice/Facility/Hospital:_____

Address: _____

(Street) (City) (State/Zip)

For the following tests:❑Colonoscopy ❑EGD ❑Cardiac Testing ❑Pathology
❑Hospital Admission/Discharge ❑H&P ❑OperativeReport

The patient requests that medical records be released or faxed to:

Name: Sandhills Endoscopy Center Address: 2631 Forest Dr Columbia SC 29204 Fax:803-254-8984

Signature:_____ Date:_____

Relationship to patient (If parent or guardian): _____

Witness: _____ Date: _____

Kievers Cunningham, M
Medical Director/ Owne

2631 Forest Drive
Columbia SC, 29204
Phone (803) 254-8449
Fax (803) 254-8984

PATIENT REGISTRATION

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Male ❑ Female ❑ Married ❑ Divorced ❑ Single ❑ Widowed

PATIENT NAME_____
(Last) (First) (MI)

ADDRESS_____ **EMAIL**_____

CITY_____ **STATE** _____**ZIP**_____ **COUNTY**_____

PHONE_____ _____ _____
(Home) (Cell) (Work)

DOB_____**SSN**_____**Race** ❑Hispanic/Latino ❑ African American ❑ White ❑ Asian ❑Declined

EMPLOYER/OCCUPATION_____ **MAY WE CONTACT YOU AT WORK?** ❑YES ❑ NO

EMERGENCY CONTACT INFORMATION:_____

EMERGENCY CONTACT NAME:_____RELATIONSHIP_____EMERGENCY PHONE # _____

INSURANCE INFORMATION: PLEASE BRING YOUR CURRENT INSURANCE CARDS WITH YOU

PRIMARY INSURANCE COMPANY_____GROUP # _____

POLICY NUMBER_____

SECONDARY INSURANCE COMPANY_____GROUP # _____

POLICY NUMBER _____

IF INSURANCE IS NOT IN YOUR NAME –PLEASE PROVIDE THE FOLLOWING INFORMATION

_____ _____ _____ _____

POLICY HOLDERS NAME **SSN** **DOB** **RELATIONSHIP TO INSURED**

ASSIGNMENT OF BENEFITS

****PLEASE NOTE: THERE MAY BE (4) SEPARATE BILLS FOR THIS SERVICE**:**
(ENDOSCOPY CENTER FEE, PHYSICIAN FEE, LABORATORY FEE, AND ANESTHESIA FEE)

I authorize Sandhills Endoscopy Center to bill and collect from my insurance company for services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE AFTER INSURANCE PAYMENTS OR DENIALS, AS WELL AS ANY CO-PAYS AND DEDUCTIBLES.

SIGNATURE: _____ **DATE**_____

PREPARATION INSTRUCTIONS:

DID YOU RECEIVE YOUR PREP INSTRUCTIONS? IF NOT, PLEASE CONTACT YOUR PHYSICIANS' OFFICE OR OUR OFFICE SO THAT WE WILL BE ABLE TO ASSIST YOU IN PREPARING FOR THE TEST.

REMEMBER: YOU MUST MAKE ARRANGEMENTS FOR YOUR DRIVER TO STAY IN THE CENTER FOR YOUR ENTIRE PROCEDURE. THANK YOU.

Patient Surgery Center Admission

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the *ambulatory surgery* center (ASC). The patient is under the care and supervision of his/her physician and it is the responsibility of the *surgery* center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the *surgery* center employees.

OTHER PROFESSIONAL SERVICES: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the *surgery* center shall not be responsible for any personal property brought by a patient to the *surgery* center, including but not limited to money, jewelry, documents, or any other articles.

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or copayments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contract the *surgery* center has signed with my insurer that states otherwise. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. I authorize payment of medical benefits to the surgery center for the services provided.

I hereby acknowledge the above statements. I also acknowledge that I have received the following items prior to the date of the procedure:

1. Rights and Responsibilities
2. Policy on Advance Directives
3. Disclosure of ownership
4. Privacy Policy
5. Grievance Policy
6. Appointment and Cancellation policy

Patient **Date** **Time** Witness Date Time

(In the event that the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

_____

Patient's Representative Witness Date/ Time

Kievers Cunningham MD
Medical Director

2631 Forest Drive
Columbia, SC 29204
Phone (803) 254-8449
Fax: (803) 254-8984

PATIENT MEDICATION RECONCILIATION FORM

Allergies/Reactions:_____

_____

Medication	Amount:	How do you take it?	How often to do you take it?	Last Date & Time you took it:	(Staff) Home Medications on Discharge ⬜ No changes in Home Medication required. Continue taking home medications. ⬜ Make the following changes to your home medications as written below.Continue all other medications as previously directed by your physician.

Continue on the back of this form if you have more medications

Source of Medication List: Check All That Apply ____Patient/Family _____Medication List
____Primary Care Physician _____Meds brought in

PhysicianSignature_____**Date:**_____

New Prescribed medications:

Medication:	**Dose:**	**Route:**	**Frequency:**

I understand that I am to take the medications listed upon my discharge from the center. I acknowledge that I have been told to contact the physicians who ordered any medications that I was taking before coming to the center to confirm if I should remain on those medications.The medication list has been reviewed with a copy given to me or my representative.

Patient Signature/Date:_____ RN Signature/Date:_____

Medications Continued:

Medication	Dose:	How do you take it?	Frequency (how often)	Last Date & Time you took it:

SANDHILLS ENDOSCOPY CENTER, LLC

PATIENT RIGHTS AND RESPONSIBILITIES POSTING

Patients, the Patient's Representative & the Patient's Health Care Surrogate have:

- The right to considerate, respectful care, provided in a safe & dignified environment, free from all forms of mental
  & physical abuse or harassment as well as exploitation. The patient, the patient representative or the patient's surrogate may exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- The right to full consideration of privacy concerning his/her medical care program. Health care professionals will conduct all confidential case discussions, consultations, examinations and treatments discreetly. This includes the right to be advised of the reason for the presence of any individual involved in his/her healthcare
- The right to confidential treatment of all communications and records pertaining to the patient's care and visit to the facility. (Except when the law requires, patients have the opportunity to approve or refuse the release of their records). If confidential communications and records are released, written consent by the patient shall be obtained. If the patient is physically or mentally unable to, written consent is required from the patient's responsible party.
- The right to access to information contained in his/her medical record within a reasonable frame of time, (within 48 hours of request, excluding weekends and holidays), to include information regarding diagnosis, evaluation, treatment and prognosis. If it is medically inadvisable to give such information to the patient, a person designated by the patient or a legally authorized person shall have access to the patient's information.
- The right to participate in the development and implementation of the patient's plan of care and to actively participate in decisions regarding this medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment. This right includes information from the patient's physician about a patient's illness, the planned course of treatment, (including unanticipated outcomes), and prospects for recovery in terms the patient can understand. If treatment is refused, the patient shall be informed of the consequences of refusal of treatment, and the reason shall be reported to the physician and documented in the patient record.
- The right to know the physician performing the procedure may have financial interest or ownership in this ASC. Disclosure of this information will be in writing and furnished prior to the start of the procedure in a language and manner the patient, the patient representative or the patient's surrogate understands.
- The right to services provided at the facility and reasonable responses to any reasonable request the patient, the patient representative or the patient's surrogate may make for service.
- The right to continuing healthcare requirements and instructions following the patient's discharge from the facility.
- The facility services are not intended for emergency care, therefore all practitioners will direct after hours' care to the closest emergency room. The patient has the right for continuing care after hours or overnight. If care is not available
  at the ASC, the patient will be transferred to a hospital.
- The right to examine and receive the fees for service. Upon request and prior to the initiation of care or treatment, the right to receive an estimate of the facility charges, potential insurance payments and an estimate of any co-payment, deductible, or other charges not paid by insurance.
- The right to refuse to participate in experimental research.

- The right to a written copy of the facility's policy on advance directives in a language and manner the patient, the patient's representative or the patient's surrogate understands. Information concerning advance directives will be made available to the patient, the patient representative or the patient's surrogate, including a description of the state laws regarding advance directives and official state advance directive forms if requested. Documentation of whether the individual has executed an advance directive will be placed in each patient chart.
- The right to knowledge of the medical staff credentialing process, upon request.
- The right to knowledge of the name of the physician who has primary responsibility for coordinating the patient's care and the names and professional relationships of other physicians and healthcare providers who will care for the patient and perform the procedure. The patient has the right to change the primary physician if another is available.
- The right to understandable marketing or advertising methods used by the facility identifying the competence and skill of the organization.
- The right to as much information about any proposed treatment or procedure as needed in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, any alternate courses of treatment or non-treatment and the risks involved in each.
- The right to know whether the patient's physician has appropriate liability insurance coverage or if the physician does not carry malpractice insurance.
- The right to be advised of the facility's grievance process should the patient wish to communicate a concern regarding treatment or care delivered
- Be informed of his/her right to discontinue care or to leave the facility against the physician's advice as well as to be advised of any risks to the patient when discontinuing care or leaving the facility.
- The right to appropriate assessment and management of pain.
- The right to remain free from seclusion or restraints of any form not medically necessary or that are used as a means of coercion, discipline, convenience, or retaliation by staff.
- The right to have a family member notified of the patient's admission as well as notification of the patient's personal physician, if requested.
- The right to express spiritual and cultural beliefs.
- The right to information regarding the patient's outcomes of care including unexpected outcomes
- The right to use a telephone and allow privacy while making a call.
- The right to be assured that reasonable safeguards will be provided for protection and storage of patients' personal belongings.
- The right to a consultation and second opinion at your request and your expense.

Patient, the Patient's Representative & the Patient's Health Care Surrogate Responsibilities

The patient, the patient's representative and/or the patient's surrogate shall be:

- Responsible for providing accurate information regarding medications along with any allergies and sensitivities.
- Responsible for providing accurate and complete information concerning the patient's present complaints, past illnesses and hospitalizations, and other matters relating to his/her health.
- Responsible for reporting perceived risks in the patient's care and unexpected changes in the patient's condition to the responsible practitioner.
- Responsible for asking questions concerning the information presented by a staff member about the patient's care or what the patient is expected to do
- Responsible for following the treatment plan established by the patient's physician, including the instructions of nurses and other health professionals who carry out the physician's orders.

- ➢ Responsible for keeping appointments and for notifying the facility or physician when the patient is unable to do so.
- ➢ Responsible for providing healthcare insurance information and assuring the financial obligations of the patient's care are fulfilled as promptly as possible.
- ➢ Responsible for the consequences if the patient refuses treatment or fails to follow the practitioner's instructions.
- ➢ Responsible for following facility policies and procedures.
- ➢ Responsible for being respectful and considerate of other patients and organizational personnel.
- ➢ Responsible for being respectful of the belongings of others in the facility.
- ➢ Responsible for the safekeeping of valuables, which should be left at home or with a designated caregiver. The ASC is not responsible for lost, stolen or broken personal items.
- ➢ Responsible for providing a responsible adult driver to transport him or her from the facility.
- ➢ Be available to participate in decision-making and provide staff with knowledge of family whereabouts.
- ➢ Parents/family have the responsibility to continue their parenting role to the extent of their ability.

These rights and responsibilities listed here and on the previous page outline the basic concepts of service at Sandhills Endoscopy Center, LLC. If you believe at any time our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director, Administrator or Director of Nursing. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

Tava Cunningham, PharmD -Practice Administrator

Kievers Cunningham, MD -Medical Director

If you have concerns about patient safety or quality care in the Sandhills Endoscopy Center, LLC, you may contact any of the following organizations:

South Carolina Department of Health & Environmental Control:
http://www.scdhec.gov/health/licen/complaint.htm
(803) 545-4370

Web site for the Office of the Medicare Beneficiary Ombudsman.

Medicare: 1-800-Medicare (Ombudsman) @
http://www.medicare.gov/navigation/help-and-support/ombudsman.aspx or
http://www.cms.hhs.gov/ombudsman/resources.asp

Patient Privacy Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this Information. Please review it carefully. You will be given a copy of this notice.

Patient Health Information: Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information includes payment, billing, and insurance information.

How we use your Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission. Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Examples of Care, Payment, and Healthcare Operations: Treatment—We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other healthcare providers who are helping in your treatment, to pharmacists filling your prescriptions, and to family members helping with your care. **Payment—**We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. **Heath Care Operations—**We will use and disclose your health information to conduct our standard internal operations, including the administration of records, the evaluation of the quality of treatment, and the assessment of outcomes.

Special use: We may use your information to contact you with appointment reminders. We may also contact you to provide information about different treatment options.

Other Uses and Disclosures: We may use or disclose health information about you for other purposes. Subject to certain requirements, we are permitted disclosure for the following purposes: **Required by Law—**We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. **Research—**We may use or disclose information for approved medical research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information. **Public Health Activities—**As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. **Health Oversight—** We may disclose information to assist in investigation and audits, and eligibility for government programs. **Judicial Proceedings—**We will disclose information in response to subpoena or court order.

Law Enforcement Purposes—We may disclose information subject to certain restrictions.

Workers' Compensation—We may release information about your workers' compensation or other programs providing benefits for work-related injuries or illness. **Military or Special Government Functions—**If a member of the armed forces, we will release information as military authorities or correctional facilities command, or for national security. **Death—**We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation programs. **Serious Threat to Health and Safety—**We may share information when needed to prevent a serious threat to your health, safety, and/or to the public. **Business Associates—**We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

Individual Rights: You have the following rights with your health information. **Request Restrictions—**You may request restrictions on some uses of this information, although we are not required to agree with this request. **Confidential Communications—**You may request that we communicate with only you. You may request a special address or phone number. **Inspect and Obtain Copies—**In most cases you have the right to look and receive a copy of your information. **Amend Information—**If you believe there are errors in your information, or information is missing, you may request that it be modified. **Accounting of Disclosure—**You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

Our Legal Requirement: We are required to provide you with this notice, to protect your information, and to abide by the terms of this notice.

Changes in a Privacy Practice: We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice and/or the changes at any time. You may contact the Director of Nursing below to answer any questions.

Complaints: If you have a complaint that may reveal we have violated this privacy statement, or do not agree with a decision that we made in regard to your information, please contact the Director of Nursing below. You may also contact the US Department of Health and Human Services. The person below may provide you with the correct address upon request.

Services. The person below may provide you with the correct address upon request.

Contact Person:

Tava Cunningham, Center Administrator 803-254-8449;

tcunningham@sandhllsendo.org

2631 Forest Dr. Colombia, SC 29204

POLICY:

It is this facility's policy to support patients' rights to make decisions regarding their health care. Patients and their representatives or surrogates have the right to have proposed medical interventions explained to their satisfaction and the right to refuse any unwanted care.

If patients do not have decision-making capacity or if they are unable to speak for themselves, they have the right to have a surrogate make treatment decisions for them.

This policy is to ensure all personnel and patients are aware the facility will honor properly executed South Carolina Advance Directives.

Patients also have the right to make an Advance Directive to help ensure that the competent adult's desires are honored if he or she becomes incapacitated. South Carolina law requires that the ambulatory surgery center, or ASC, honor any patient's advance directive. Sandhills Endoscopy Center will work with the patient's Health Care Power of Attorney if the patient is not able to communicate his or her desires.

South Carolina law, however, characterizes Do Not Resuscitate Orders as a part of the patient's Living Will. (SC Code of Laws Title 44 Chapter 77) The Living Will goes into effect only when the patient is terminally ill or permanently unconscious.Since SandhillsEndoscopy Center performs only elective procedures on healthy patients, the facility will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.

Sandhills Endoscopy Center staff will be trained to provide patients with basic information on Advance Directives so that the patient, patient representative or patient surrogate may have questions answered. Information on state law and state approved forms will be available to patients who request additional information.

Definitions:

1. **Advance Directive**: "Advance Directive" means a written instruction such as a living will or health care power of attorney, recognized under State law (whether by statute or by the courts of the State) and relating to the provision of health care when the individual is incapacitated. South Carolina provides by statute for two types of Advance Directives, Living Will and Health Care Power of Attorney.

2. **Health Care Power of Attorney**: This document allows the patient to name an adult to make decisions about his/her healthcare—including decisions about life-sustaining treatment—when the patient can no longer speak for himself. The health care power of attorney goes into effect when the patient's doctor certifies that he/she is no longer able to appreciate the nature and implications of his/her condition.

A. A South Carolina Health Care Power of Attorney must be signed in the presence of two witnesses. These witnesses cannot be:

i. the health care agent (person with power of attorney)
ii. related to the patient by blood, marriage or adoption
iii. the attending physician or an employee of the attending physician
iv. the person directly financially responsible for the patient's care
v. a person directly entitled to any portion of the patient's estate after death either under a will or by operation of law
vi. a beneficiary of the patient's life insurance policy

vii. or anyone with a claim against the patient's estate upon death

viii. At least one of the witnesses must not be an employee of the health facility in which the patient is a patient.

3. **South Carolina Declaration of a Desire for a Natural Death, or Declaration (Living Will)**: A living will. This declaration allows the patient to state wishes about health care in the event that he/she can no longer make health care decisions and the patient is terminally ill or in a persistent vegetative state. In order for this document to be legal, it must be signed in the presence of two individuals and notarized. The notary may act as one of the witnesses. The witnesses cannot be

i. related to the patient by blood, marriage or adoption

ii. the attending physician or an employee of the attending physician

iii. the person directly financially responsible for the patient's care

iv. a person directly entitled to any portion of the patient's estate after death either under a will or by operation of law

v. a beneficiary of the patient's life insurance policy

vi. or anyone with a claim against the patient's estate upon death

PROCEDURE:

1. The ASC will provide the patient with written information concerning its policy on Advanced Directives prior to the start of the procedure.

A. Information concerning the ASC's policy on Advance Directives will be provided to all patients as a part of their pre-procedure documents
B. At registration patients will be asked whether they have advance directives and the patient's questions will be answered concerning ASC policy if necessary.

2. The ASC will provide education to the patient on Advance Directives, if requested by the patient.

A. ASC staff will receive training on Advance Directives so that they may answer basic patient questions.
B. A packet of information and forms will be available to give to patients who have additional questions or who wish to create an Advance Directive. This information, if requested, may be mailed to patients before the procedure or given to patients the day of the procedure

3. If a patient has an Advance Directive, it will be documented in the patient's chart

A. During registration each patient will be asked if he/she has an Advance Directive. If the patient has an Advance Directive, a copy will be made for the patient chart.
B. During the pre-op patient interview, the patient will be asked again if he/she has an Advance Directive. The type of Advance Directive or "N/A" will be documented in the pre-op portion of the chart.
C. A copy of the Advance Directive must be placed in the chart. The copy will be placed in the front of the patient chart.
D. If the patient did not bring a copy, that fact should be documented and the contents/type of the Advance Directive will be noted in the chart and witnessed by a staff member and the responsible adult

E. If the patient is transferred to another facility, the Advance Directive must accompany the patient as a part of the patient's medical record.

SPECIAL CONSIDERATIONS:

1. Patients being educated/informed must be 18 years of age or older, have decision making capacity, and be acting upon their own free will.
2. Sandhills Endoscopy Center staff will be trained to provide patients with basic information on Advance Directives so that patient, patient representative or patient surrogate may have questions answered. Information on state law and state approved forms will be available to patients who request additional information. Training of staff will be documented.
3. More information on South Carolina Advance Directives Requirements is available at http://aging.sc.gov/legal/Pages/AdvanceDirectives.aspx or SC Code of Laws, Title44, Chapter 66, Section 10 and SC Code of Laws, Title 62, Chapter 5.

Kievers Cunningham, MD Medical Director

2631 Forest Dr
Columbia, SC 29204
Phone (803) 254 8449
Fax (803) 254 8984

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

An entity formed by a physician owns this facility. This physician has become the owner as a result of his commitment to quality healthcare and service to their patients. Your physician may be an owner of this facility.

Physicians with ownership in this facility: Dr. Kievers L. Cunningham

Please be advised of the following:

- The facility may have a financial relationship with your physician as indicated above. A schedule of typical fees for services provided by the facility is available at your request.
- You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship or a healthcare facility other than Sandhills Endoscopy Center.
- Your physician will not treat you differently if you choose to obtain health care services at a facility other than Sandhills Endoscopy Center.

If you have any questions concerning this notice, please feel free to ask your physician or our Center Administrator. We welcome you as a patient and value our relationship with you.

Missed Appointment and Cancellation Policy

A cancellation for you can be a cancellation for two. If you are unable to keep a scheduled appointment, please be considerate of others and provide a notice of 3 business days (when possible) so that we can accommodate another patient.

If you do not provide a notice of 3 business days, you will be charged $50 for your time slot. If you cancel the day of the procedure, you will be charged $100.

2631 Forest Drive
Columbia, SC 29204
Phone 803-254-8449
Fax0803-254-8984

Kievers L. Cunningham, MD

PATIENT GRIEVANCE POLICY

PURPOSE: To establish a process whereby patients or their authorized representatives may have their grievances and complaints resolved in a prompt, reasonable and consistent manner.

POLICY:

- A **Complaint** is defined as a verbal expression of dissatisfaction by the patient/ family regarding care or services provided by Sandhills Endoscopy Center which can be resolved at the point at which it occurs by the staff present. Most complaints will have simple solutions that can be promptly addressed and are considered resolved when the patient/family is satisfied with the action taken on their behalf.
- Grievance is defined as a formal verbal or written expression of dissatisfaction with some aspect of care or service that has not been resolved to the patient/family's satisfaction at the point of service. All verbal or written complaints of abuse, neglect, patient harm or the risk of patient harm, or a violation of the Patient Rights and Responsibilities are examples of grievances. A verbal or written complaint sent to the Risk Management committee or any request from a family to treat a complaint like a grievance will be considered a grievance.

A grievance may be filed by a patient, a patient's representative, or an employee without interference or fear of discrimination or reprisal.

SUBSTANTIATED ALLEGATIONS MUST BE REPORTED TO THE STATE, LOCAL, OR BOTH AUTHORITIES.

Grievance Information:

Medicare: 1-800-Medicare (Ombudsman) @ WWW.CMS.HHS.GOV/CENTER/OMBUDSMAN.ASP
South Carolina Department of Health: *(803) 898-DHEC (3432)* @ http://www.scdhec.gov **Sandhills Colonoscopy Center:** Director of Nursing 803-254-8449
The Joint Commission Organization: (630) 792-5286

PATIENT GRIEVANCE PROCEDURE:

A. Step 1 – Staff will provide grievance forms to patients whenever requested. (Patient Grievance Form F)
B. Staff should inquire at this time whether there is anything they can do to assist the patient or resolve the matter. All grievances received by clinical staff members will immediately be forwarded to the Director of Nursing. Any grievance received by nonclinical staff shall be reported immediately to the Center Administrator. The DON or Administrator will attempt to address and resolve the grievances. The Medical Director will be notified immediately.
C. If a resolution is reached, the DON, Center Administrator, and the complainant will sign and date the grievance form as satisfied. The Medical Director will be notified.
D. If a resolution cannot be reached, the Patient Grievance Form and relevant documentation as necessary will be given to the Medical Director. The Medical Director will meet with the DON and Center Administrator to discuss the grievance. The complainant will be notified within 7 days of the decision. The response will be written and include: 1. the decision; 2. the steps taken on behalf of the patient to investigate the grievance; 3. the results of the grievance process; and 4. the date of completion.
E. All grievances will be documented.
F. If a patient and/or his/her representative requests a meeting to air his/her grievance, the meeting will be held as soon as possible.
G. Every grievance will be reported to the Risk Management Committee and the Governing Board for documentation, reporting, and improvement.
H. All grievances are confidential.