GI Excellence, Inc.

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GI Excellence Patient Rights and Privacy

IN ACCORDANCE WITH HEALTH AND SAFETY CODES, THE AMBULATORY SURGICAL CENTER (ASC) AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS:

Patient rights will be exercised without regard to sex or culture, economic, educational or religious background or the source of payment for his or her care.

1. Considerate and respectful care.
2. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see the patient.
3. Receive information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.
4. Receive as much information about any proposed treatment or procedure as he or she may need 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 and knowledge of the person who will carry out the procedure or treatment.
5. Participate actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment.
6. Full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
7. Confidential treatment of all communications and records pertaining to his or her care and his or her stay in the ASC. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.
8. Reasonable responses to reasonable requests he or she may make for services.
9. He or she may leave the ASC, even against the advice of his or her physicians.
10. Reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
11. Be advised if ASC/personal physician proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in any research projects.
12. Be informed by his or her physician, or a delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from the Surgery Center.

For complaints or comments about your medical care, ask to speak with either Dr. Milan Chakrabarty, Dr. Indraneel Chakrabarty, Deana Gascione, Director of Operations. You may also contact: The California Department of Health Services, Division of Health Facilities, by phone at 1-888-456-0630, via mail at 625 E. Carnegie Dr., #280, San Bernardino, CA 92408, or go to the website of the Medicare Beneficiary Ombudsman www.cms.hhs.gov/center/ombudsman.asp. Also, visit www.medicare gov or call 1-800-633-4227.

Physician Financial Interest and Ownership of the

Hemet Endoscopy Center (ASC) is physician owned. The physician who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at an another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

Ownership Roster:

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Advance Directives

It is the policy of **GI Excellence, Inc.** to not honor advance directives presented by a potential patient. If it is felt that the patient's health status is such that an advanced directive would be prudent, the surgery will be rescheduled at a center of higher care or at a later date when health conditions have improved. Prior to the presentation of an advance directive the patient will be informed of the policy not to honor the directive. The patient will be informed that in the event of an emergency he/she will be revived and transferred to Hemet Valley Medical Center.

With my signature below, I hereby acknowledge that I have been given a copy of this form and the opportunity to read the facilities Patient Rights, privacy practices and their policy on Advance directives before my procedure.

Signed_____ Date_____

Print Name if Parent
or Legal Guardian:_____