Welcome to
Suncoast Endoscopy
Of Sarasota
2089 Hawthorne St. Sarasota, Fl 34239

Suncoast Endoscopy of Sarasota was developed by some of the area's most experienced and qualified gastroenterologists to offer you high quality medical care in a safe, comfortable environment.
The four endoscopy rooms in our facility are equipped with technology that is state of the art and on the cutting edge of medicine. Our highly skilled and qualified physicians perform procedures utilizing this equipment. This allows them to diagnose and treat a variety of gastrointestinal conditions.
Our experienced staff provides excellent personalized service to our patients and physicians.

Important information you should know:

Before your procedure, failure to follow these instructions may result in cancellation of your procedure.

- For your safety and in an effort to help reduce your wait time on the day of your procedure. We will call to confirm your appointment within 3 days of your scheduled procedure..
- Carefully follow all instructions from your doctor regarding preparation.
- Notify your doctor before coming to the center if there is any change in your physical condition, such as cold or fever.
- **Do not drink or eat anything after midnight prior to your procedure, unless your doctor has given you other instructions. No milk products allowed.** You may brush your teeth, remember not to swallow anything.**No peppermints, chewing gum, smoking or hard candy the morning of procedure.**
- Please do not take any medication after midnight unless instructed by your doctor. If you are taking medications for diabetes, high blood pressure or are taking aspirin, Coumadin, or blood thinners, notify your doctor because dosage adjustments may be necessary prior to your procedure.
- **It is your responsibility** to arrange in advance for a responsible adult to drive you home from our facility and remain with you or check on you if possible for the first 24 hours after your procedure. Please contact our office if any questions regarding this.
- **You cannot drive yourself home or take public transportation unaccompanied.**
- **Important:** Please complete the medication form you received from the doctor's office and bring it with you to our facility.

On the day of your procedure:

- Wear loose comfortable clothing. Leave all valuables, including jewelry and cash at home. **No lockers are provided.** Bring socks for warmth.
- **BRING YOUR DRIVERS LICENSE, INSURANCE CARDS(S) AND READING GLASSES WITH YOU. WE ARE A SEPARATE FACILITY FROM YOUR DOCTORS OFFICE. WE NEED THIS INFORMATION FOR OUR RECORDS**
- **All female patients** age 55 and under will be required to submit a urine sample the day of the procedure at our facility to rule out pregnancy.

After your procedure:

- Your doctor will give you specific written instructions for your care at home.
- **Do not drive your car, drink alcoholic beverages, operate machinery, or sign any legal documents until the day after your procedure.**

Patient's Rights:

- You have the right to personal privacy and confidentiality of your clinical records, to receive care in a safe setting, and to be free from all forms of abuse or harassment.
- You have the responsibility to provide accurate medical and insurance information and to follow the health care facility rules and regulations affecting patient care and conduct.

Advance Directives:

- It is the policy of Suncoast Endoscopy of Sarasota to respond to any cardiac or respiratory emergency or other life threatening situations in such a manner as to save the life of the patient; therefore, Suncoast Endoscopy of Sarasota declines to implement the element of do not resuscitate on the basis of conscience. If the patient should suffer a medical emergency and is in need of transferring to a higher level of care (i.e., a hospital), the Advance Directive document will accompany the patient in transfer and be made available to the admitting facility. Once the patient transfer is completed, the admitting facility's policies and procedures involving Advanced Directives will take precedence and supersede this policy. A notice of this policy will be given to the patient in the physician's offices. If you are opposed to this policy, you must address this issue with your physician prior to the procedure.
  We **do not** administer **blood products** at our center but we will ask our patients to sign a statement prior to the procedure indicating their consent to, or denial of, blood products in a case of an emergency transfer.

Handling of Grievances:

- You have the right to voice any grievances regarding your treatment or care that is, or fails to be, furnished.
- You may file a grievance with the facility's appointed representative by calling (941) 952-1145 or through the Office of the Medicare Beneficiary Ombudsman by visiting: www.cms.hhs.gov/center/ombudsman.asp.

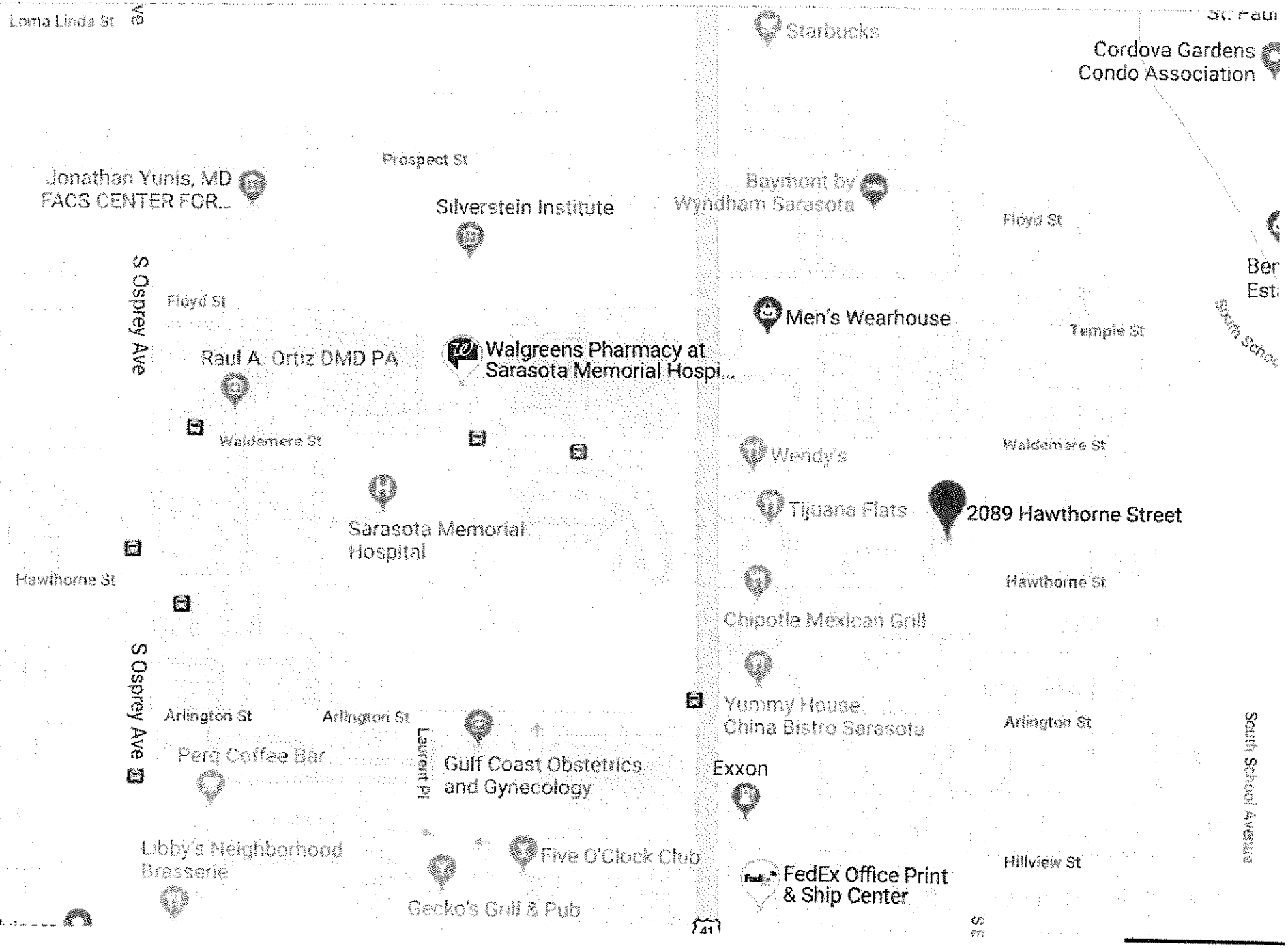
My Physician's Ownership in the Facility:

- Your physician may have a "beneficial interest" in this endoscopy center and you have the right to choose another facility in which to receive the services your physician has determined are necessary.
- The following physicians have a "beneficial interest" in Suncoast Endoscopy of Sarasota: F. S. Corbett, MD, Marc Bernstein MD, Brent Murchie, MD

Insurance and Billing:

- Most insurance companies favor outpatient endoscopy centers.
- **Since insurance coverages differ, patients should be prepared to pay any co-payment, unmet deductible, or co-insurance payment at the time of procedure.**
- Suncoast Endoscopy of Sarasota does accept MasterCard, Visa, American Express and Discover Card
- Due to the number of insurance plans, we suggest that you contact your insurance company if you have specific question regarding your coverage.
- There is a facility fee for each procedure. This bill **does not include** the services of your doctor who performed the procedure, the anesthesia services, and laboratory fees.
- **For Questions regarding fees :**
  FDHS Anesthesia, LLC. 941-269-0557 or 1-800-242-5080
  FDHS Billing(Facility/Lab Fees) – 941-757-4820

Due to Covid-19
circumstances,
no family members are
allowed in the facility
with patients who are
here for procedures at
this time.


Loma Linda St
Starbucks
Cordova Gardens Condo Association
Prospect St
Jonathan Yunis, MD FACS CENTER FOR...
Silverstein Institute
Baymont by Wyndham Sarasota
Floyd St
S Osprey Ave
Floyd St
Men's Wearhouse
Temple St
Raul A. Ortiz DMD PA
Walgreens Pharmacy at Sarasota Memorial Hospi...
Waldemere St
Waldemere St
Wendy's
Tijuana Flats
2089 Hawthorne Street
Sarasota Memorial Hospital
Hawthorne St
Hawthorne St
Chipotle Mexican Grill
S Osprey Ave
Yummy House China Bistro Sarasota
Arlington St
Arlington St
Arlington St
Lauvart Pl
Perq Coffee Bar
Gulf Coast Obstetrics and Gynecology
Exxon
Libby's Neighborhood Brasserie
Five O'Clock Club
FedEx Office Print & Ship Center
Hillview St
Gecko's Grill & Pub
41

Suncoast Endoscopy Center of Sarasota

Federal Disclosure Form

Bill of Rights – In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of Suncoast Endoscopy of Sarasota:

- TO be treated with respect, consideration and dignity.
- TO be provided with the appropriate privacy.
- TO expect that all disclosures and records are treated confidentially, except when required by law, and to be given the opportunityto approve or refuse the release.
- TO be provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be the legally authorized person.
- TO be given the opportunity to participate in decisions involving their healthcare, except when participation is contraindicated for medical reasons.
- TO receive, from his/her physician, information necessary to give informed consent prior to the start of any procedure and/or treatment, except it emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved, and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy. The patient has the right to know the name of the person responsible for the procedures and/or treatment.
- To be informed, when appropriate, of treatment policy for an unemancipated minor not accompanied by an adult.
- TO refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.
- TO be informed as to:
  Expected conduct and responsibilities as a patient, services available from the facility, provisions for after-hours and emergency care, fees for services, payment policies, the right to refuse participation in experimental research, methods for expressing grievance and suggestions to the facility, and the procedure for reporting public health concerns to the appropriate authorities.
- TO be informed of their rights to change primary or specialty physicians if other qualified physicians areavailable.
- In the event the patient would like to report complaints, the web site is www.medicare.gov/ombudsman.

Patient Responsibilities:

- TO exhibit behavior that shows respect and consideration for other patients, family, visitors, and personnel of thefacility.
- TO assure that the financial obligations for healthcare rendered are paid in a timely manner.
- TO accept consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given to them by the doctor or their healthcare team member.
- TO provide the facility, to the best of their knowledge, with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, existence of advance directives, medications and other pertinent data.
- TO follow the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or otherpersonnel authorized by the facility to so instruct the patient.
- TO notify the facility of any change in theircondition.
- TO keep their appointment for scheduled procedure. If they anticipate a delay or must cancel the scheduled procedure, it istheir responsibility to notify the facility as soon as possible.
- TO carry out their pre-op instructions as supplied by the office or facility.
- TO hold the responsibility of the disposition of their valuables, as the facility does not assume thisresponsibility.
- TO know what their rights are as a patient, and to be able to request a copy of these rights if desired.

Notice of Ownership Information:

Suncoast Endoscopy of Sarasota is owned by the following local physicians: **F. Scott Corbett, M.D., Marc Bernstein M.D., Brent Murchie, M.D.** FDHS Anesthesia, LLC. is owned by the following local physicians: **F.Scott Corbett,M.D.**

These physicians have become owners as a result of their commitment to quality healthcare and service to their patients. Under current Florida law, a physician-owned facility may not provide items or services to a patient unless the patient signs a written notice disclosing certain matters. You have the right to choose where to receive services, including an entity in which your physician may have financial relationship.

Notice of Policy Regarding Advance Directives:

In compliance with the Self Determination Act and Florida law and rules regarding advance directives, be advised that your signature below acknowledges receipt of the following information regarding Advance Directives. Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury. Two common advance directives are: Living Wills and Durable Power of Attorney for Health Care. In the ambulatory setting, if a patient should suffer cardiac or respiratory arrest or other life threatening ituations, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient. If you disagree, you must address this issue with your physician before you sign this form. **INITIAL**_____**DATE**_____

This Federal Disclosure Form has been discussed with me and explained to my full satisfaction and understanding.

Patient Name (Printed)_____**Date Signed** _____

Patient Signature_____**Date of Birth**_____

Witness of Signature_____**Date**_____

WHO IS DRIVING YOU HOME TODAY?

DRIVER'S NAME:_____

RELATIONSHIP TO YOU:_____

DRIVER'S PHONE NUMBER:_____
PLEASE INDICATE RESPONSE:
DRIVER WILL WAIT IN LOBBY:_____YES _____NO
DRIVER WILL NEED TO BE CALLED:_____YES _____NO
CAN DRIVER BE AT BEDSIDE IN RECOVERY ROOM:_____YES _____NO

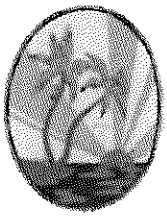
Suncoast Endoscopy of Sarasota is committed to providing the highest level of patient care. To achieve this objective we ask our patients or their caretaker to complete a brief patient satisfaction survey after their visit.

To better serve you we have automated this process. Within 48 hours, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey online will be entered into a monthly drawing for a $100 gift certificate to Amazon.com

Please write legibly and provide the email address to forward the survey to in the boxes below:

Privacy Statement: We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

PATIENT LABEL



Suncoast Endoscopy of Sarasota

2089 Hawthorne Street, Suite #100
Sarasota, FL 34239
Phone: (941)952-1145

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship:_____Phone: _____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Suncoast Endoscopy of Sarasota.

Do we have your permission to:

Call you at home? □ Yes □ No

If yes, may we leave the following information on your home answering machine or voicemail:

Appointment Information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No

May we call you at work? □ Yes □ No

If yes, may we leave the following information at your work answering machine or voicemail:

Appointment Information □ Yes □ No
Billing Information □ Yes □ No
Medical Information □ Yes □ No

PHONE NUMBER YOU CAN BEST BE REACHED _____

I give my permission to share the following information with the person(s) named below:

Name:_____Relationship_____
Appointment □ Yes □ No Billing □ Yes □ No

Name:_____Relationship_____
Appointment □ Yes □ No Billing □ Yes □ No

_____ _____
Patient Signature Date

_____ _____
Witness Date

SUNCOAST ENDOSCOPY MEDICATION RECONCILIATION FORM

[ ] NO KNOWN ALLERIES

ALLERGIES	REACTION

[ ] NO MEDICATIONS *[ ]SEE DISCHARGE INSTRUCTIONS*

MEDICATION

******List all medications, including over the counter and herbal meds, and all vitamins, minerals, and supplements. Please include any medications stopped for this procedure.******

MEDICATION	DOSE	HOW OFTEN	LAST DOSE	FOR DOCTOR'S INSTRUCTIONS ONLY: CONTINUE	FOR DOCTOR'S INSTRUCTIONS ONLY: STOP TAKING	COMMENTS

New Medication to Take Following Today's Visit:

1.
2.

Discharge Order: MD evaluated and cleared patient for discharge to Home / Hospital.
MD Time:_____ **PACU RN Time:**_____

FOR STAFF USE ONLY	
Preop:	**PATIENT LABEL**
Anesthesia:	
Circulator:	
PACU:	
Physician:	

I acknowledge that I have received a copy of this form:_____

Patient Signature

SUNCOAST ENDOSCOPY OF SARASOTA

ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits:
I hereby assign any and all medical and procedure benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Suncoast Endoscopy of Sarasota for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility:
Self -pay charges, non- covered charges, coinsurance, copayment, deductible and other amounts for which you are responsible, are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for payment of all fees, for you are responsible as determined by Suncoast Endoscopy or, if applicable, your health benefit plan. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law.

I have requested medical services from Suncoast Endoscopy of Sarasota on behalf of myself and/or my dependents, and understand that by making this request, I become financially responsible all charges or ,if I am a health plan member, all coinsurance, copayment, deductible and other out of pocket amounts for which I am responsible under the terms of my health benefit plan. I further understand that amounts for which I am responsible are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

The estimated facility charge for your procedure to be billed to your insurance company at Suncoast Endoscopy of Sarasota is:

Colonoscopy:$1300.00-2400.00
Upper Endoscopy: $1100.00 - $2200.00
Double Procedure: $2200.00 - $3500.00
Flexible Sigmoidoscopy: $350.00 - $600

Authorization to Release Information:
I hereby authorize Suncoast Endoscopy of Sarasota to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

Disclosure of Physician Ownership Interest:

Your physician,_____, does/does not have a financial relationship with the center. You are entitled to obtain the services for which you have been referred to Suncoast Endoscopy of Sarasota at the location of your choice.

Alternative sources of the services for which you have been referred to this entity are as follows:

Sarasota Memorial Hospital
1700 S. Tamiami Trail
Sarasota, FL 34239

Doctors Hospital
5731 Bee Ridge Rd.
Sarasota, FL 34233

_____ _____
Patient/Responsible Party Signature Date

PATIENT LABEL

_____ _____
Witness Date

SUNCOAST ENDOSCOPY OF SARASOTA
2009 HAWTHORNE STREET, SUITE 100 SARASOTA, FLORIDA 34239 TEL (941) 952-1145 FAX (941) 952-1175

CONSENT TO MEDICAL SERVICES INCLUDING TRANSFUSION(S)

Please INITIAL EACH Line (1 thru 13)

_____1. I DO / DO NOT ← *(circle one – applies to #1 only)*
authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the attending physician. I understand that despite the exercise of due care the transfusion or blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types.

_____2. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV or hepatitis.

_____3. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.

_____4. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform the facility immediately since the scheduled procedure could cause harm to my child or to myself.

_____5. I understand that in the rare event hospitalization is required during or immediately after procedure, my physician will arrange for my transfer to a local hospital.

_____6. I verify I have not eaten or taken fluids, not even water, since midnight, unless otherwise instructed by my physician/prep instructions

_____7. Suncoast Endoscopy of Sarasota has provided me with information regarding the Patient's Bill of Rights & the Privacy Act (HIPAA) so I may be fully informed prior to treatment. (Privacy & Rights posters are posted in lobby)

_____8. Suncoast Endoscopy of Sarasota has informed me that they always attempt to resuscitate a patient and transfer the patient to a hospital in the event of deterioration. This information is given at the time of the procedure is scheduled.

_____9. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.

_____10. **I understand that it is my responsibility and I have arranged for a responsible adult to drive me home from Suncoast Endoscopy and remain with me following my procedure. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my procedure or as directed by my physician.**

_____11. **I understand it is my responsibility to fully disclose all my medical history.**

_____12. I have received a copy of the nondiscrimination notice and language assistance tag (posted in lobby)

_____13. Photographs/videotapes: I authorize my physician to photograph/video my procedure(s) at the discretion of my physician. I understand that the photographs/videos will be used only for the purpose of treatment services, medical study, education and/or documentation for my medical records.

Date_____ **Time**_____ **Patient's Signature**_____

Date_____ **Time**_____ **Witness to Signature**_____

If patient is unable to sign complete the following:

Date_____ **Time**_____ **Signature**_____

Relationship_____ **Witness to Signature**_____

PATIENT LABEL

FDHS Anesthesia, LLC, Anesthesia Dynamics, LLC & Lakewood Ranch Anesthesia

Providing Professional Anesthesia Services for patients at Suncoast Endoscopy of Sarasota

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to FDHS Anesthesia, LLC (FDHSA), Anesthesia Dynamics, LLC (AD), and Lakewood Ranch Anesthesia (LRA) all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between FDHSA/AD/LRA /LRA and my insurance company. I authorize and direct the insurance company to pay all such benefits to FDHSA/AD/LRA. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and FDHSA/AD/LRA .

Authorization to Release Claims Information: I hereby authorize FDHSA/AD/LRA it employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize FDHSA/AD/LRA its employees and agents to act on my behalf in completing claims including any appeal process.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that FDHSA is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

Signature of Patient/Authorized Guardian Signature **Date**

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at Suncoast Endoscopy of Sarasota. by FDHSA. FDHSA contracts and employees certified registered nurse anesthetists as part of the anesthesia care team.

Anesthesia services will be billed separately from the services of Suncoast Endoscopy of Sarasota.

For billing questions or concerns, please call: 1-800-242-5080 or 941-269-0557.

In the event that FDHSA/AD/LRA is not a participating provider with your insurance plan, FDHSA/AD/LRA will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses due to FDHSA/AD/LRA but-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.