FINANCIAL POLICY
For Hillmont GI, Springfield ASC & Anesthesia Services

Hillmont GI is dedicated to providing you the most efficient care and service possible. **Your understanding of our financial policy is an essential element of your care and service**. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. If you have questions regarding our policy, please feel free to contact our billing department at 215-402-0800 ext 226.

Full payment is due at the time of service. HMO and other "managed care" plans require that primary care physicians provide the patient with a referral to be presented to the specialty care physician. This form must specify a request for a consultation or for treatment, and reason for the referral. **If your insurance company requires a referral and you do not bring a referral with you, we will reschedule your visit**. If you have insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you if we are a provider on your plan. Outstanding balances after insurance are due within (30) days of the billing statement date. **Any balance unpaid after ninety days will be turned over to our collection agency Northwest Collectors, Inc. unless other arrangements are made with our billing department.**

It is your responsibility to know the details of your particular insurance policy. **Not all services are covered by all insurance carriers**. Services and diagnosis which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in ordered to obtain coverage by insurance. If your insurance has a **copay** it is due at the time of service. It is against the law for us to waive a copay. If we do not collect them your insurance company can charge us with billing fraud. If you have a **deductible**, you are responsible for all charges until the deductible is met.

If your insurance carrier has a **"network**" of providers it is your responsibility to make sure we are an "in network" provider prior to obtain services. If we are not "in network", we will still be happy to provide services: however the percentage of charges or deductible for which you are responsible will be greater.

It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

Disclosure of Springfield Ambulatory Surgery Center Ownership

I have been informed that the physician who is rendering services to me may have an ownership interest in Springfield Ambulatory Surgery Center. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the Springfield Ambulatory Surgery Center.

_____ _____

Signature Date

SPRINGFIELD AMBULATORY SURGERY CENTER

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

As a patient of the **Springfield Ambulatory Surgery Center,** you have the right to receive the following information in advance of the date of the procedure.

PATIENT'S BILL OF RIGHTS:

Every patient has the right to be treated as an individual with his/her rights respected. The facility and medical staff have adopted the following list of patient's rights.

Patient Rights:

•To receive respectful, considerate and dignified care given by competent personnel.
•To be provided, upon request, the name of his/her attending practitioner, the names of all other practitioners directly participating in his/her care, and the names and functions of other health care persons having direct contact with the patient.
•The right to have records pertaining to his/her medical care treated as confidential, except as otherwise provided by law.
•The opportunity to approve or refuse release of his/her medical care records prior to submission to any party, including third parties based on contractual arrangements, except as otherwise provided by law.
•Consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.
•To expect emergency procedures to be implemented without unnecessary delay.
•The right to know what ambulatory care facility rules and regulations apply to his/her conduct as a patient.
•To be given the opportunity to participate in decisions involving his/her health care, except when such participation is contraindicated for medical reasons.
•to good quality care and high professional standards that are continually maintained and reviewed.
•to full information in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.
•Except in cases of emergency, the practitioner shall obtain the necessary informed consent prior to the start of the procedure.
•A patient, or if unable to give informed consent, a person responsible to the patient, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person shall give informed consent prior to actual participation in the program. A patient or responsible person may refuse to continue in a program to which he or she has previously given informed consent.
•The right to refuse the participation of Center in the patient's treatment.
•Right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
•to medical and nursing services without discrimination based upon age, race, color, religion, gender, national origin, handicap, disability or source of payment.
•A patient who does not speak English or is deaf shall have access, when necessary, to interpretation services.
•A patient who is blind or deaf shall have alternative communicative assistance available to them, if requested.
•Shall have access to the information contained in his/her medical records at the ambulatory care facility, unless the attending practitioner for medical reasons specifically restricts access.
•To expect good management techniques to be practiced within the ambulatory care facility. Techniques shall make effective use of the patient's time and shall avoid personal discomfort of the patient.
•To be transferred when an emergency occurs to another facility and requires transfer to a location capable of providing emergency services, with notification to both patient or their responsible party and the facility prior to the patient's transfer.
•To examine and receive a detailed explanation of his/her bill.
•To expect that the ASF will provide information for continuing health requirements following discharge and the means for meeting them.
•The right, without recrimination, to voice comments, suggestions, complaints and grievances regarding care; to have those complaints reviewed and when possible, resolved; and when not resolved, to obtain information regarding external appeals, as required by state and Federal law and regulations.
•To be informed verbally and in writing, in terms the patient could understand, of his/her rights, responsibilities, and expected conduct by the ambulatory care facility at the time of admission.
•The right to information covering services available at the ASF, the fees related to those services, and the payment policies governing restitution for services rendered.
•The right to information on the provision of after hours and emergency services for care and treatment rendered at the ASF.
•The right to information on advance directives, as required by state or Federal law and regulations**.** Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.
If the patient or patient's representative wants their Advance Directives to be honored, the Patient will be offered care at another facility that will comply with their wishes.
If you request, an official state Advance Directive Form will be provided to you
•The right to be provided, upon request, information pertaining to the process of credentialing of the practitioners rendering care and treatment at the ASF.
•The right not to be misled by the organization's marketing or advertising regarding their competence and capabilities.
•To obtain names, addresses, and telephone numbers from the Center Director of the governmental offices were complaints may be lodged.
•To obtain names, addresses and telephone numbers of offices where information concerning Medicare and Medicaid coverage can be obtained.
The following are the names and/or agencies you may contact:

Patricia Hebert (Center Director)
Springfield Ambulatory Surgery Center
1528 Bethlehem Pike
Flourtown, PA 19031
215-402-0600

You may contact your state representative to report a complaint:

Pennsylvania Department of Health website:
www.health.state.pa.us

Sites for address and phone numbers of regulatory agencies:
Complaint Hotline: 1-800-254-5164

Medicare Ombudsman website
www.medicare.gov/Ombudsman/resources.asp

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

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

Physician Financial Interest and Ownership:

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

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

_____,
hereby acknowledge receipt of the Patient Rights & Notification of Ownership.

Signed:_____
Date:_____

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