

**Hillmont G.I., p.c.**  
**125 Medical Campus Drive**  
**Suite 104**  
**Lansdale, PA 19446**  
**Tel: 215-997-9377 Fax: 215-997-8891**

Dear \_\_\_\_\_,

Thank you for scheduling an appointment with Dr. \_\_\_\_\_ on \_\_\_\_\_  
\_\_\_\_\_. It is our pleasure to welcome you to Hillmont GI  
in advance of your first visit.

Enclosed is a patient registration form and medical history form. Please complete the forms and bring them with you for your appointment. We would be happy to answer questions for you by phone prior to your visit, our number is 215-997-9377.

We appreciate you selecting Hillmont GI for your medical care and will work hard to serve your needs.

Sincerely,

Physicians and Staff of Hillmont GI

# Hillmont GI / Springfield ASC

## PATIENT REGISTRATION FORM

Please **PRINT CLEARLY** so we can read your information accurately. Thank you.

SOCIAL SECURITY #: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

GENDER:  Male /  Female DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE #: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ *(for you to access your health information electronically)*

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Partnered  Widowed

EMERGENCY CONTACT #1: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY CONTACT #2: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHARMACY PHONE #: \_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

### FOR GOVERNMENT HEALTHCARE ANALYSIS USE

#### RACE (Only check one selection):

- American Indian or Alaska Native
- Asian
- Black or African-American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- White
- Do not wish to provide

#### ETHNICITY (Only check one selection):

- Hispanic or Latino
- Not Hispanic or Latino
- Do not wish to provide

#### PRIMARY / PREFERRED LANGUAGE (Only check/write one selection):

- Chinese
- Korean
- Other: \_\_\_\_\_
- English
- Spanish
- Do not wish to provide
- Hindi
- Vietnamese
- Do not wish to provide
- Italian
- American Sign Language

**PRIMARY INSURANCE INFORMATION**

INSURANCE CO. NAME: \_\_\_\_\_

The insured policyholder is the patient

(if under spouse, fill in spouse's name and date of birth)

Insured's Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

INSURANCE CO. NAME: \_\_\_\_\_

The insured policyholder is the patient

(if under spouse, fill in spouse's name and date of birth)

Insured's Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS**

**COMMERCIAL INSURANCE PATIENTS:** I AUTHORIZE the release of any medical information necessary to process my insurance claims. I AUTHORIZE and request payment of medical benefits directly to my physicians. I AGREE that authorization will cover all medical services rendered until such authorization is revoked by me. I AGREE that a photocopy of this form may be used in place of the original.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICARE PATIENTS:** I AUTHORIZE any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare 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 myself or to the party who accepts assignment. I UNDERSTAND it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**ALL PATIENTS:** OK to share your protected health information? **YES / NO** (circle one). If YES, please list the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*\*TO ALL PATIENTS: HIPAA NOTICE\*\*\*  
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT**

I acknowledge that I have received our Notices of Privacy Practices Brochure:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# *Hillmont GI / Springfield ASC*

## *Medical History Form*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds

Do you have a living will/advanced directive?    Yes    No    Please provide a copy at your next visit

**Family History (include relation if applicable):**

Colon Cancer: \_\_\_\_\_ Colon polyps: \_\_\_\_\_

Ulcerative Colitis or Crohn's Disease: \_\_\_\_\_ Liver Disease: \_\_\_\_\_

**Medications/Dose/Frequency (include over-the-counter drugs):**

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Allergies to medications, latex or IV dye: \_\_\_\_\_

Any previous reactions to anesthesia: \_\_\_\_\_

**Blood Thinner Treatment:**            Coumadin/Warfarin            Plavix            Aspirin

Do you smoke?    Yes    No    # of packs per day: \_\_\_\_\_ / # of years smoke: \_\_\_\_\_ / Quit?: \_\_\_\_\_

Do you use alcohol?    Yes    No    # of drinks per week: \_\_\_\_\_

History of excessive alcohol use: \_\_\_\_\_

History of drug/substance abuse: \_\_\_\_\_

**Prior Surgical History (list all operations):**

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Heart Attack	Angina	Pacemaker	Coronary Blockages
Congestive Heart Failure	Irregular Heart Rhythm	Artificial Valve	Heart Valve problems
Stent or Angioplasty	Bypass	Defibrillator	Bleeding Problems
Diabetes	High Blood Pressure	Stroke/TIA	Asthma
COPD/Emphysema	Sleep Apnea	Home Oxygen	Kidney disease
Kidney dialysis	Thyroid disease	Lupus	Sarcoid
HIV	Hepatitis B or C	Pancreatitis	Anemia
Anxiety/Depression	Bipolar disorder	Rheumatoid arthritis	
Prior blood transfusion	History of Cancer: _____		

**Which of the following are you experiencing? Please check either 'Yes' or 'No'**

**Constitutional**

Recent weight change            No    Yes  
 Fever                                    No    Yes  
 Fatigue                                 No    Yes

**Eyes**

Blurred vision                        No    Yes  
 Glaucoma                                No    Yes

**Ears/Nose/Mouth/Throat**

Hearing loss                            No    Yes  
 Ringing in the ears                  No    Yes  
 Mouth sores                             No    Yes

**Cardiovascular**

Chest pain                                No    Yes  
 Shortness of breath                  No    Yes  
 Swelling of the ankles                No    Yes

**Respiratory**

Chronic cough                         No    Yes  
 Spitting up blood                     No    Yes  
 Wheezing                                 No    Yes

**Genitourinary**

Burning when urinating                No    Yes  
 Blood in urine                            No    Yes

**Musculoskeletal**

Joint pain or swelling                 No    Yes  
 Back pain                                 No    Yes  
 Muscle pain                                No    Yes

**Skin**

Rash                                        No    Yes  
 Itching                                     No    Yes

**Gastrointestinal**

Poor appetite                            No    Yes  
 Swallowing difficulty                 No    Yes  
 Heartburn                                 No    Yes  
 Nausea/Vomiting                        No    Yes  
 Bloating                                    No    Yes  
 Belching                                    No    Yes  
 Regurgitation                             No    Yes  
 Constipation                                No    Yes  
 Diarrhea                                    No    Yes  
 Abdominal pain                         No    Yes  
 Recent change in bowel habits        No    Yes  
 Rectal bleeding                         No    Yes  
 Black, tarry stools                        No    Yes  
 Blood in stools                            No    Yes

**Neurological**

Headaches                                No    Yes  
 Seizures                                    No    Yes  
 Strokes                                     No    Yes  
 Numbness                                 No    Yes

**Psychiatric**

Memory loss or confusion                No    Yes  
 Depression/Anxiety                        No    Yes

**Endocrine**

Heat or cold intolerance                 No    Yes  
 Excessive thirst                         No    Yes  
 Excessive urination                        No    Yes

**Hematological**

Bleeding/bruising tendency                No    Yes  
 Anemia                                      No    Yes  
 Blood transfusion                         No    Yes

**Are you pregnant?**

No    Yes

**How did you hear about us?** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

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# HILLMONT GI, PC

1811 Bethlehem Pike, Building C, Suite 300, Flourtown, PA 19031 Phone: 215.402.0800

125 Medical Campus Drive, Suite 104, Lansdale, PA 19446 Phone: 215.997.9377

Victor Araya, MD – Gerald Bertiger, MD – Robert Boynton, MD – Steven Nack, MD – Benjamin Raile, MD – James Taterka, MD

FAX: (215) 836-2429

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## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

*Please Note: Copy Fee May Be Charged For Medical Records*

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual organization:

**RELEASE TO NAME/ORGANIZATION:** Hillmont GI, PC

**ADDRESS:** 1811 Bethlehem Pike **CITY:** Flourtown **STATE:** PA **ZIP:** 19031

**FAX NUMBER:** 215-836-2429 **PHONE:** 215-402-0800

**DATES AND TYPE OF INFORMATION TO DISCLOSE:**

- Complete Records
- Procedure Reports
- Consultations
- Radiology or Laboratory Reports
- Other: \_\_\_\_\_

**THE PURPOSE OF DISCLOSURE IS:**

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other: \_\_\_\_\_

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME & RELATIONSHIP:** \_\_\_\_\_

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**For Internal Use Only:** Date Received: \_\_\_\_\_ Date PHI Sent: \_\_\_\_\_ Date Completed: \_\_\_\_\_

# **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 order 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.

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Signature

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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 where 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](http://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](http://www.medicare.gov/Ombudsman/resources.asp)

**Medicare:** [www.medicare.gov](http://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**



**Notice of Privacy Practices  
Hillmont G.I., PC**

**WELCOME!**

We are pleased to provide you with this information about how we protect the privacy and confidentiality of information about you (**Patient Health Information**) and how we use and disclose your Patient Health Information.

**Patient Health Information** includes symptoms, test results, diagnoses, treatment, and related medical information. It also includes appointment, billing, payment, and insurance information. (Under some circumstances we may be required by law to use or disclose the information even without your permission).

**We Use and Disclose Your Patient Health Information:**

**For treatment purposes to bill and obtain payment for the services rendered,** for evaluation of your care including consultation with other healthcare professionals and necessary communication with laboratories, radiologists, pharmacies, and family member participation in your care, etc.

**When required by law** we report gunshot wounds, suspected neglect or abuse, or similar injuries and events, also, in response to a subpoena or court order, and (subject to certain restrictions) in response to requests by law enforcement officials.

**For public health activities** such as collection of vital statistics, identifying diseases, recalls related to dangerous products, and similar information to public health authorities. We also supply information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

**For health oversight** to assist in investigations and audits, and to determine eligibility for government programs, insurance programs, etc.

**For approved medical research.**

**To avoid threats to your health or safety** or to that of another person or the general public.

**As required by military or special government agencies** like the armed forces and correctional institutions or for national security purposes.

**For requests from Worker's Compensation,** or similar programs providing benefits.

**For routine communications, like mailings or phone calls,** for example billing statements, appointment reminders/changes and recall notices. We may ask that test results be sent to our office. We may also discuss test results that we ordered or treatment outcome follow-ups. Information and alternatives about your treatment or other health related benefits or services that may be of interest to you might be sent/given to you. In such instances the envelopes or fold-over postcards we send will not have our office name as the return address. Instead that address will

be either “125 Medical Campus Drive, Suite 104” or “Flourtown Commons, Bldg. C, Suite 300”. In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign a disclosure authorization you may revoke that authorization. You may request a list of instances which disclose health information about you, if any, for reasons other than treatment, payment or healthcare operations.

## **YOUR RIGHTS**

You have the following rights with regard to your health information. Please contact the person listed at the end of this brochure to exercise these rights.

**You may request restrictions** on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

**You have the right, in most cases, to review or obtain a copy of your health information.** We may charge you a small fee for making copies. You have the right to request that we **amend** or **correct** information.

### **Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person indicated at the end of this brochure. You may also send a letter to the U.S. Department of Health and Human Services. The person indicated at the end of this brochure will provide you with the appropriate address. You will not be penalized in any way for filing a complaint.

### **OUR LEGAL DUTY**

We are required by law to protect and maintain the privacy of your health information and to provide you with the notice currently in effect. We may change our policies at any time. All significant changes will be stated in a revised document. A notice of the revision will be posted in the waiting area. Also, copies of the revised statement will be available at the check-out window.

#### **Privacy Issues Contact Person**

If you have any questions, requests, or complaints, please contact our designated Privacy Officer by writing to:

Privacy Officer  
Hillmont G.I., PC  
1811 Bethlehem Pike, Suite C-300  
Flourtown, PA 19031

# Directions to Lansdale Office



## **Hillmont GI, p.c.**

125 Medical Campus Drive Suite 104  
Phone: 215-997-9377 Fax: 215-997-8891  
Office Hours: 7:40am- 4:40pm  
Phones opened Daily: 9:00am- 5:00pm

### **From Route 309 South: Allentown/Quakertown**

Take Route 309 south to Colmar. Make a right turn onto Broad Street. Stay on Broad Street for approximately 1-1/2 mile and make a left turn onto Medical Campus Drive.

### **From Route 309 North: Philadelphia**

Take Route 309 north to Cowpath Rd/PA-463. Continue straight for 1.4 miles and turn left onto N. Broad St. Continue 0.7 mile and make left turn onto Medical Campus Dr.

### **From the Northeast Extension, Pennsylvania Turnpike**

Take the Northeast Extension (Route 476) of the Pennsylvania Turnpike to the Lansdale Exit (#31). After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 mile and make right turn onto Medical Campus Drive.

### **From Route 202 South: Doylestown**

Take Route 202 south to the five-point intersection in Montgomeryville, where routes 202, 309 and 463 intersect. Make right turn onto Route 463 (Cowpath Road). Go approximately 1.4 miles to traffic light at Broad Street. Turn left and continue 0.7 mile and make left turn onto Medical Campus Drive.

### **From Route 76 (Schuylkill Expressway): Center City Philadelphia**

Take Route 76 west to the Plymouth Meeting/Conshohocken – Route 476 north Exit. Take the Northeast Extension (Route 476) to the Lansdale Exit (#31), approximately 15 miles. After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 mile and make right turn onto Medical Campus Drive.

### **From Philadelphia International Airport**

Take Interstate 95 south to Route 476 north. Follow the signs to the Northeast Extension, Pennsylvania Turnpike – Route 476 north. Take the Northeast Extension to the Lansdale Exit (#31). After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 miles make a right turn onto Medical Campus Drive.