

ST. PETER'S

SURGERY & ENDOSCOPY CENTER

Patient Handbook, Patient Notice of Privacy Practices and Patient's Bill of Rights and Responsibilities

1375 Washington Avenue • Suite 201
Albany, New York 12206-1063
Ph: 518.533.3420 / Fax: 518.533.3424

Dear Patient,

Your physician has scheduled your upcoming procedure at St. Peter's Surgery & Endoscopy Center. Please review the Center's Patient Handbook, which details your rights and responsibilities. Should you have any questions, you may contact us at the telephone number listed on the front cover.

Thank You

ATTENTION:

If you speak one of the following languages, assistance is available to you free of charge.

Please ask for assistance from a staff member.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.

Yiddish: רופט. אפצאל פון פריי סערוויסעס הילף שפראך אייך פאר פארהאן זענען, אידיש רעדט איר אויב: אויפמערקזאם

Bengali: ল য় করন: যিদ আপিন বাংলা, কথা বলেত পোৱেন, তাহেল িন:খরচায় ভাষা সহায়তা পিরেষবা উপল

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

Arabic: برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Urdu: ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو، ہیں بولتے اردو آپ اگر: خبردار

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.

St. Peter's Surgery & Endoscopy Center

Complies with all applicable Federal and State Civil Rights Laws and does not discriminate on the basis of age, race, color, religion, national origin, handicap, disability, sex, sexual orientation, or source of payment, and any other basis prohibited by federal, state or local law or by accreditation standards.

St. Peter's Surgery & Endoscopy Center

- Provides free qualified interpreter language services to people whose primary language is not English.
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, accessible electronic formats)

If you need these services, contact our office at (518) 533-3420. You may also contact the office of your Attending Physician/Surgeon, who will inform The Center of the service needed. It is extremely beneficial if notification is provided, with as much advance notice as possible, prior to your scheduled visit.

If you believe that St. Peter's has failed to provide these services or discriminated in another way on the basis of age, race, color, religion, national origin, handicap, disability, sex, sexual orientation, source of payment or any other basis prohibited by federal, state or local law, you can file a grievance with:

James Torre, Executive Director
1375 Washington Avenue, Suite 201
Albany, NY 12206
Telephone: 518-533-3420 Fax 518-533-3424.

You may file a grievance in person, by phone or by mail or fax. If you need help filing a grievance, James Torre is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

Or by mail/email/phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
OCRComplaint@hhs.gov
1-800-368-1019
TTD: 1-800-537-7697

St. Peter's Ambulatory Surgery Center dba St. Peter's Surgery & Endoscopy Center

Welcome to the St. Peter's Surgery & Endoscopy Center, ("The Center"). This Patient Handbook was designed to introduce you to The Center, provide you with some basic information regarding The Center, and most importantly to explain your rights and responsibilities as a patient. Please read this Handbook carefully. If you need assistance in understanding any information in the Handbook, including if necessary an interpreter, please let us know. We will be happy to assist you.

It is our intent to assist you, in whatever manner necessary, throughout your visit at The Center. This includes assistance with understanding all aspects of your care, helping you to make informed decisions, and helping you to understand your rights and responsibilities.

The Center staff understands that having to undergo surgery or GI procedures can be stressful and frightening. Please rest assured that we will do everything possible to provide you with the finest quality healthcare. We will also do the best we can to accommodate all of your, and your responsible adult and/or family members, non-medical needs. If necessary, multiple patient family members are welcome at The Center. However, we feel compelled to advise that space and seating is sometimes limited. **Therefore, we are requesting that patients and parents of patients consider the comfort of their own and other family members, and when possible, limit the number of family members at The Center to as few as is absolutely necessary.** Thank you for your understanding.

MISSION, GOALS, AND OBJECTIVES OF THE ST. PETER'S SURGERY AND ENDOSCOPY CENTER

The purpose of St. Peter's Surgery & Endoscopy Center is to promote the health of a broad section of the community through ownership and operation of an ambulatory surgery center located at 1375 Washington Avenue, Albany, New York. The provision of care to the indigent is an acknowledged component of The Center's purpose.

The mission of The Center is to provide cost-effective outpatient services using modern state-of-the-art technology in a friendly and caring environment by highly skilled compassionate staff serving Albany, New York and surrounding communities.

OBJECTIVES:

- Streamline delivery of medical care to the surgical outpatient and provide the utmost quality services.
- Make outpatient surgery experience less anxiety producing.
- Utilize the most cost-effective measures for the patient and the healthcare delivery system.
- Provide an environment that is aesthetically pleasing for the patient, physician and employee and promote customer service.
- Reduce the risk of nosocomial infection for the surgical patient.

ADVANCED DIRECTIVES

Advance Directives are written or verbal statements made by a patient indicating treatment wishes in the event the patient becomes incapacitated. An Advance Directive may specify medical treatment the individual consents to or refuses, appoint another individual as a healthcare agent, or both. In New York State there are three main types of Advance Directives. They are:

Healthcare Proxy - Allows the patient to appoint a healthcare agent. A healthcare agent is someone they trust, over the age of 18, to make health care decisions for them if they are unable to make decisions for themselves. Only a Health Care Proxy Form can be used for this purpose.

Living Will - Allows the patient to leave written instructions that explain their health care wishes, especially about end-of-life care. A living will cannot be used to name a healthcare agent; the Health Care Proxy form must be used for this purpose.

Do Not Resuscitate Order (DNR Order) - Allows the patient to express their wish to withhold cardiopulmonary resuscitation, CPR. CPR is emergency treatment to restart the heart and/or lungs when the patient's breathing or circulation stops.

St. Peter's Surgery & Endoscopy Center respects a patient's right to make decisions regarding his or her health care, and will assist patients in whatever means necessary to accomplish this. **However, due to the elective and lower risk nature of procedures performed at The Center, The Center requires patients to suspend or not issue DNR Orders or other Advance Directives related to withholding emergent or life-sustaining treatment.** Where possible, The Center prefers to use all measures possible to sustain Life.

If you have executed any type of Advanced Directive you need to let us know. You should also bring a copy with you on the day of your procedure.

If the Advance Directive is related to withholding life-sustaining treatment, such as a DNR Order, The Center staff and/or your attending physician will discuss with you the benefits and risks of keeping such directive in place. **You will be required to execute a temporary consent that suspends your DNR Order or other Advance Directive, related to withholding emergent or life sustaining treatment, while receiving care at The Center.** Such consent will allow The Center staff to perform resuscitative life-sustaining treatment in the event of an emergency. Should an emergency occur, you will be given resuscitative life-sustaining treatment, stabilized, and then transferred to St. Peter's Hospital. Once at the Hospital further treatment or withdrawal of treatment already begun will be ordered in accordance with your wishes and your advance directives pursuant to Hospital policy.

If you wish to issue or keep in effect a DNR Order or other Advance Directive related to withholding life-sustaining treatment **you will NOT be able to receive care at The St. Peter's Surgery & Endoscopy Center.** If requested, The Center and the attending physician will work together to make arrangements for your treatment at another healthcare facility.

If you would like more information regarding advanced directives in New York State, you may visit:
<https://www.health.ny.gov/publications/1503.pdf>

A summary of this information is contained within this handbook in the section entitled "Planning in Advance for your Medical Treatment."

A Health Care Proxy Form, instructions for completion, and answers to frequently asked questions is located in the last section of this handbook. You may also obtain New York State Health Care Proxy Forms by downloading them at: <http://www.health.state.ny.us/forms/doh-1430.pdf>.

ST. PETER'S AMBULATORY SURGERY CENTER, IS A JOINT VENTURE BETWEEN, AND OWNED BY:

St. Peter's Hospital
315 South Manning Blvd.
Albany, NY 12208

AGC Associates, LLC
1375 Washington Ave., Suite 101
Albany, NY 12206

PHYSICIAN OWNERS OF AGC ASSOCIATES, LLC ARE:

Joseph Polito, MD
Bora Gumustop, MD
Jonathan Barsa, MD
Matthew Ben, MD
Richard Clift, MD

Joseph Choma, MD
Domenico Viterbo, MD
Carla F. Fernando-Gilday, MD
John Buhac, MD
James Puleo II, MD

Sean Sheehan, MD
Mandeep Bhamra, MD
Jeffrey Gerson, MD
Robert Gianotti, MD
Matthew Warndorf, MD

Sajid Hussain, MD
Neil Volk, MD
Reena Patel, MD
Shai Posner, MD*
Xinjun Zhu, MD*

* - Effective 1/1/2023

PATIENT NOTICE OF PRIVACY PRACTICES

St. Peter's Surgery & Endoscopy Center

Effective: June 2019

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. Any revised Notice of Privacy Practices would be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail. A copy of the current Notice of Privacy Practices will be prominently displayed in our office at all times and posted on our website.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information

Prior to disclosing your protected health information to outside health care providers or to obtain payment, we will obtain your general consent, usually at your first visit to our facility.

- (a) **Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that already has obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to your primary care physician. We also may disclose protected health information to other specialist physicians who may be treating you.
- (b) **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we provide for you, determining your eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities.
- (c) **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of the center. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to an insurer or accreditation agency which performs chart audits. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information, as necessary, to contact you to remind you of your scheduled procedure.
- (d) **Business Associates:** We will share your protected health information with third party "business associates" that perform various activities for The Center (e.g., computer consulting company, law firm or other consultants). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
- (e) **Health Related Benefits/Treatment Alternatives:** We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our HIPAA Privacy and Security Officer to request that these materials not be sent to you.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing, except to the extent that the center has taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI;
- Most uses and disclosures of psychotherapy notes (if the center maintains psychotherapy notes); and
- Other uses and disclosures not described in the notice

C. Other Permitted and Required Uses and Disclosures That May Be Made With Your Permission or Opportunity to Object

- (a) **Others Involved in Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment.
- (b) **Information to your family members:** Unless prior preference is expressed to the center, a deceased patient's health information may be disclosed to a family or other member or other persons who were involved in the individual's care or payment for health care prior to the individual's death if such protected health information is relevant to person's involvement.

D. Other Permitted and Required Uses and Disclosures that may be made without your Consent or Authorization

- (a) **Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law.
- (b) **Public Health:** We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We also may disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- (c) **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- (d) **Health Oversight:** We may disclose your protected health information to a governmental agency for activities authorized by law, such as audits, investigations, and inspections.
- (e) **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.
- (f) **Product Monitoring and Recalls:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, and biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or in connection with post-marketing surveillance, as required by law.
- (g) **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- (h) **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes included (1) legal processes, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the center, and (6) medical emergency (not on the center's premises) and it is likely that a crime has occurred.
- (i) **Decedents:** Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties. Protected health information does not include health information of a person who has been deceased for more than 50 years.
- (j) **Organ/Tissue Donation:** Your health information may be used or disclosed for cadaver organ, eye or tissue donation purposes.
- (k) **Criminal Activity:** We may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- (l) **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for authorized military purposes, as required by law.
- (m) **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
- (n) **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
- (o) **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy regulations.

2. YOUR RIGHTS

A. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a medical record maintained by the center for as long as we maintain the protected health information. We may charge you our standard fee for the costs of copying, mailing or other supplies we use to fulfill your request.

B. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You also may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

In most circumstances, your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if you request us to restrict disclosures to health plans that we would normally make as part of payment or health care operations, we **must** agree to that restriction if the protected health information relates to health care which you have paid out of pocket in full.

If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to

request with your physician. You may request a restriction using the form for requests for restrictions on protected health information from the HIPAA Privacy and Security Officer, or you may provide us your request, in writing. Your request must include (a) the information you wish restricted; (b) whether you are requesting to limit the center's use, disclosure, or both; and (c) to whom you want the limits to apply.

C. You have the right to electronic copies of your protected health information when requested. Where information is not readily producible in the form and format requested, the information must be provided in an alternative readable electronic format as agreed to by you and the center may charge a reasonable cost based fee for labor in copying protected health information and postage where you request that information be transmitted via mail or courier.

D. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask us to contact you by mail, rather than by phone at home. You do not have to provide us a reason for this request. We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our HIPAA Privacy and Security Officer.

E. You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you that we maintain. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our HIPAA Privacy and Security Officer if you have questions about amending your medical record.

F. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies generally to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. However, you do have the right to an accounting of disclosures for treatment, payment or health care operations if the disclosures were made from an electronic health record.

Your right to an accounting of disclosures excludes disclosures we may have made to you, or to family members or friends involved in your care, or for notification purposes.

You have the right to receive specific information regarding other disclosures that occurred up to six years from the date of your request (three years in the case of disclosures from an electronic health record made for treatment, payment or health care operations). You may request a shorter timeframe. The first list you request within a 12-month period is free of charge, but there is a charge involved with any additional lists within the same 12-month period. We will inform you of any costs involved with additional requests, and you may withdraw your request before you incur any costs.

G. You have the right to obtain a paper copy of this Notice from us.

H. You have the right to receive notice in the event of a breach of unsecured protected health information. This means that you will receive notice if a breach of your protected health information is discovered within 60 days of discovery.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Privacy and Security Officer of your complaint. We will not retaliate against you for filing a complaint.

If you have any questions, complaints, concerns, grievances, and/or would like additional information, you may contact the Center's HIPAA Privacy and Security Officer James Torre, at 533-3427, or in writing at St. Peter's Surgery & Endoscopy Center, 1375 Washington Ave., Suite 201, Albany, NY 12206-1063.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Each patient treated at the St. Peter's Surgery & Endoscopy Center has the right to:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor, or other basis protected by federal, state or local law;

2. Be treated with consideration, respect and dignity including privacy in treatment;
3. Be informed of the services available at The Center;
4. Be informed of the provisions of off-hour emergency coverage;
5. Be informed of and receive estimate of the charges for services, view list of health plans and the hospitals that the Center participates with; eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. Receive an itemized copy of his/her account statement, upon request;
7. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. Receive from surgeon/physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. The consent shall include, at a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of such actions;
10. Refuse to participate in experimental research;
11. Voice grievances and recommended changes in policies and services to The Center's staff, the operator and the New York State Department of Health without fear of reprisal;
12. Express complaints about the care and services provided and to have The Center investigate such complaints. The Center is responsible for providing the patient or his/her designee with a written response within 30 days, if requested by the patient, indicating the findings of the investigation. The Center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by The Center's response, the patient may complain to the New York State Department of Health's Office of Health Systems Management, and/or the Medicare Ombudsman;
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment;
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any health care practitioner and/or health care facility except as required by law or third-party payor contract;
15. Have access to his/her medical record pursuant to the provisions of section 18 of the Public Health Law, 10 NYCRR Subpart 50-3, and Federal HIPAA law. For additional information link to: Access to Your Medical Records (https://www.health.ny.gov/publications/1449/section_1.htm#access) and Do I Have the Right to See My Medical Records? (<https://www.health.ny.gov/publications/1443/>)
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;
17. When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy form is available from the Center;
18. View a list of the health plans and the hospitals that the Center participates with;
19. Receive an estimate of the amount that you will be billed after services are rendered;
20. Receive care in a safe setting, free from all forms of abuse or harassment;
21. Expect emergency procedures to be implemented without unnecessary delay; including expedient and professional transfer to another facility when medically necessary,
22. Good quality care and high professional standards that are continually maintained and reviewed;
23. Be advised of participation in a medical care research program or donor program; the patient shall give consent prior to participation in such a program; a patient may also refuse to participate and/or continue in a program that he/she has previously given informed consent to participate in;
24. Refuse drugs or treatment and be told what effect this may have on your health;
25. Receive all the information that you need to give informed consent for an order not to resuscitate, DNR Order. You also have the right to designate an individual to give this consent for you, should you become incapacitated;
26. Have his/her rights exercised by the person appointed under State law to act on their behalf, should they be judged incompetent by a court of competent jurisdiction under applicable State law; and
27. Accurate information regarding the services, competence and capabilities of The Center.

Each patient treated at the St. Peter's Surgery & Endoscopy Center has the responsibility to:

1. Treat all staff and providers with common courtesy and respect. Violence, foul language or abusive behavior are not acceptable. Verbal threats, or acts of violence will not be tolerated and may result in removal from the facility and/or prosecution;
2. Follow instructions given by his/her surgeon, anesthesiologist, and operative care givers;
3. Provide Surgery Center staff with all medical information which may have an effect on services provided at the Surgery Center;
4. Provide the Surgery Center with all information regarding third-party insurance coverage;
5. Fulfill financial responsibility, for all services received, as determined by the patient's insurance carrier;
6. Have a responsible party drive them home and accompany them for 24 hours following their procedure/surgery.

ST. PETER'S SURGERY & ENDOSCOPY CENTER AFFILIATES AND IMPORTANT BILLING INFORMATION

St. Peter's Surgery & Endoscopy Center is affiliated with the following Hospitals:

St. Peter's Hospital

Samaritan Hospital

Samaritan Hospital – Albany Memorial Campus

The Center participates with most major insurance plans. To inquire about participation with your specific insurance plan, please call The Center at 518-533-3420, see the list below or visit The Center website at: www.StPeters-Surgery-Endoscopy-Center.com.

Some patients who receive services at The Center require anesthesia and/or pathology services. Anesthesia services at The Center are provided by Anesthesia Group of Albany, P.C. When required, based upon the judgement of your physician, pathology specimens are most often sent to St. Peter's Hospital for preparation and then reviewed by physicians from Capital District Pathology Associates PLLC. Certain gastroenterology patients may require additional pathology specimens which would be sent to CDx Diagnostics. If anesthesia and/or pathology services are required, there will be separate billings from anesthesia and two bills for pathology. One pathology bill from St. Peter's Hospital, technical component, and a second pathology bill from Capital District Pathology Associates, PLLC, professional component. If you have additional pathology specimens sent to CDx Diagnostics, then you may also receive a bill from CDx Diagnostics. There will also be a separate bill from your surgeon or gastroenterologist.

To determine which insurance plans Anesthesia Group of Albany, P.C. participates with you may call 518-465-0803, or review the letter available in The Center waiting area. To determine which insurance plans Capital District Pathology Associates, PLLC participates with you may call Med Associates at 518-389-1801. To determine in which insurance plans CDx Diagnostics participate with you may call client services at 866-363-6239. To determine in which insurance plans St. Peter's Hospital participates please visit the following website, www.sphp.com/paying-for-your-care. You must contact your surgeon's office directly or the gastroenterology office – Albany Gastroenterology Consultants, PLLC, to determine in which insurance plans they participate. Albany Gastroenterology Consultants, PLLC, may be contacted at 518-438-4483, or you may visit their website at www.albanygi.com.

If you are covered by an insurance plan with which The Center, or any of the above providers, does not participate, claims will still be submitted to your carrier as a courtesy to you. However, you will be responsible for any balance remaining after your insurance has processed the claims. If your insurance plan is non-participating with The Center, or with any of the additional healthcare providers listed above, and you would like to request an estimate of the amount that may be due, absent unforeseen medical circumstances, you may contact any of the providers at the same phone numbers listed above. They will all be happy to provide you with a written estimate of this information.

Should you have any other questions or need direction with whom to call, please feel free to contact The St. Peter's Surgery & Endoscopy Center billing office at 518-533-3420. Office hours are 8:30 am to 5:00 pm. Thank you, and we look forward to assisting with both the medical and business aspects of your upcoming gastroenterology procedure or surgery.

Currently, St. Peter's Surgery & Endoscopy Center participates with the following insurance plans:

Aenta	Cigna	No Fault & Workman's Comp.	PHCS Network
Blue Shield of NENY	Empire BCBS, including BlueCard	Medicaid - NYS Only	Today's Option PPO only
Cancer Services Program	Excluding Medicare Plans	Medicare / Railroad Medicare	United Health Care
CDPHP	New York Empire Plan	Multiplan Network	
Champus / Tricare	Fidelis Care	MVP	

Please be advised that this list is subject to change. For the most updated list, please visit our website at www.StPeters-Surgery-Endoscopy-Center.com, or you may call The Center directly, between the hours of 8:30 am and 5:00 pm, at 518-533-3420.

Questions or Complaints: If you have a concern, problem or complaint related to any aspect of the provision of your care, speak to your doctor, nurse or other staff member. If facility staff have not resolved the problem, you may contact the New York State Department of Health by mail or phone. You may call the toll-free number at 1-800-804-5447, email hospinfo@health.state.ny.us, or you may file a complaint in writing and send it to:

New York State Department of Health
Centralized Hospital Intake Program ATTN:
Program Director – Mailstop CA-DCS
Empire State Plaza
Albany, New York 12237

You may also contact the **Medicare Ombudsman** at **1-800-633-4227** or www.medicare.gov/ombudsman/activities.asp

Planning in Advance For Your Medical Treatment

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started and to have treatment stopped once it has begun.

Planning In Advance

Sometimes because of illness or injury people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you do not plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available within this publication and may be printed directly from the Department of Health website at www.health.state.ny.us and click on Info for Consumers.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly and convincingly cover the treatment decisions that must be made. For example, if you just write down that you do not want “heroic measures,” the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation (CPR)

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members or others close to you can decide.

Patients are provided with the description of state law prepared by the State Health Department entitled “Planning in Advance For Your Medical Treatment”; the publication, “Appointing Your Health Care Agent— New York State’s Proxy Law,” which contains a sample (usable) health care proxy form; and a summary of the hospital’s policy regarding the implementation of these rights.

10NYCRR, 400.21 (d) (1) (i, ii, iii)

Questions or comments: hospinfo@health.state.ny.us

Revised: April 2008

St. Peter's Surgery & Endoscopy Center

Appointing Your Health Care Agent

The New York Health Care Proxy Law allows you to appoint someone you trust, for example, a family member or close friend to decide about treatment for you if you lose the ability to decide for yourself. You can appoint your "health care agent" by simply using the attached Health Care Proxy form.

Writing a health care proxy can assure that, should a time come when you cannot express your desires, your loved ones or doctor will not be forced to make choices for you without the guidance of your previously- expressed wishes, values and religious beliefs.

Planning for the time when a serious illness may prevent you from deciding for yourself requires conversation and reflection with those who are closest to you. Advances in medical technology have brought about choices you may not have considered before. It is important that this technology contribute to the way you want to live your life. As you talk over your decisions with family, friends and your physician, keep in mind that health care seeks to enable you to live in keeping with your goals and values. Let those who are closest to you know what your preferences are concerning medical treatment.

Why should I choose a health care agent?

If you become too sick to make health care decisions, someone else must decide for you. Appointing an agent assures that your medical treatment is in accord with your wishes by:

- allowing your agent to stop treatment when he or she decides that is what you would want or what is best for you under the circumstances;
- choosing one family member to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide; or
- choosing someone outside your family to decide about treatment because no one in your family is available or because you prefer that someone other than a family member decide about your health care.

How can I appoint a health care agent?

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need lawyer, just two adult witnesses. You can use the form printed here, but any form including the appropriate information is fine.

When would my health care agent begin to make treatment decisions for me?

Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make your own health care decisions. As long as you are able to make treatment decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any treatment decisions that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accord with your wishes and interests. If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures unless he or she clearly knows your wishes.

How will my health care agent make decisions?

You can write instructions on the proxy form. Your agent must follow your oral and written instructions, as well as your moral and religious beliefs. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interests.

Who will pay attention to my agent?

All hospitals, doctors and other health care facilities are legally required to honor the decisions by your agent. Neither your health professional nor your health care facility is required to honor your agent's decision if it is contrary to their religious beliefs or sincerely held moral convictions. In such event, you would likely be transferred to another facility/health professional willing to honor your agent's decision. If a hospital objects to some treatment options (such as removing certain treatment) they must tell you or your agent IN ADVANCE.

What if I change my mind?

It is easy to cancel the proxy, to change the person you have chosen as your health care agent or to change any treatment instructions you have written on your Health Care Proxy form. Just fill out a new form. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent and you get divorced or legally separated, the proxy is automatically cancelled.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is acting as your agent.

Is a health care proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care treatment. It is generally used to declare wishes to refuse life-sustaining treatment under certain circumstances. In contrast, the health care proxy allows you to choose someone you trust to make treatment decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstance change and can make decisions you could not have known would have to be made. The health care proxy is just as useful for decisions to receive treatment as for decisions to stop treatment. If you complete a Health Care Proxy form, but also have a living will, the living will provides instructions for your health care agent, and will guide his or her decisions.

Where should I keep the proxy form after it is signed?

Give a copy to your agent, your doctor and any other family members or close friends you want. You can also keep a copy in your wallet or purse or with other important papers.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

Can my health care agent make decisions for me about organ and/or tissue donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes. However, New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

This was adapted from material provided by The New York State Dept. of Health.
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About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

If I become terminally ill, I do/don't want to receive the following treatments . . .

If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions.

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- psychosurgery
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional such as a nurse or social worker before you sign it to

make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member, or close friend to be your agent. If you select a doctor as your agent he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you

are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing

Filling Out the Proxy Form

- | | |
|----------|--|
| Item (1) | Write your name and the name, home address and telephone number of the person you are selecting as your agent. |
| Item (2) | If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say it here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment. You may also state your wishes about organ or tissue donation(s). |
| Item (3) | You may write the name, home address and telephone number of an alternate agent. |
| Item (4) | This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire. |
| Item (5) | You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address. |

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____
hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

(Unless your agent knows your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

(name, home address and telephone number)

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

(5) Your Signature _____
Address _____
Date _____

(6) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

ST. PETER'S
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