EXPLANATION OF YOUR BILL

You are scheduled for a procedure at Thunderbird Endoscopy Center. The total cost may be comprised of four different fees: Thunderbird Endoscopy Center, Arizona Digestive Health, Westside Anesthesia, and Arizona Digestive Health Pathologist.

THUNDERBIRD ENDOSCOPY CENTER

Thunderbird Endoscopy Center's fee: Co-pays, Co-Insurance, and Deductibles are due at the time of service; a **verification specialist will attempt to contact you to relay any amounts due on the day of service.** If your insurance company finds you are responsible for an additional balance after processing the claim, you will be billed separately for that amount and payment will be due within 30 days. If you have any **questions** regarding your bill from Thunderbird Endoscopy Center, please call the **Billing Department** at **(602) 424-4041**.

ARIZONA DIGESTIVE HEALTH

Arizona Digestive Health fee: Your physician's fee. If you have any **questions** regarding your physician's bill, please call the **Billing Department** at **(602) 843-1265**, **prompt 2.**

Westside Anesthesia Services Plc

Westside Anesthesia fee: The sedation fee. If you have any **questions** regarding your bill for anesthesia services, please call the **Billing Department** at **602-343-7954**.

ARIZONA DIGESTIVE HEALTH **ADH Pathology— (602) 264-9100** or AmeriPath A Quest Diagnostics Company **AmeriPath— (602) 441-2000**

The **Pathology fee** is for any **biopsies** taken during your procedure. We cannot predict if or how many biopsies you may **have before** your procedure. You will be billed by the above **Pathology** groups reviewing the tissue. Please call them with billing **questions**.

Interpreting your insurance explanation of benefits (EOB):

- **Total Charges:** This is the total amount each provider will bill to insurance.
- **Allowed Amount:** This is the total amount expected to be paid by insurance and/or patient combined. (It is also called the negotiated amount or contracted amount).
- **Payable amount:** This is the amount that the primary insurance will pay.
- **Patient responsibility:** This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the "patient responsibility," depending on your contract.

I have read and understand the above information.

_____ _____

Patient Signature Date

_____

Print Name

THUNDERBIRD
ENDOSCOPY CENTER

General Instructions

You have been scheduled for a procedure at Thunderbird Endoscopy Center. Enclosed is your paperwork. Please complete and bring back, on the day of your appointment. Listed below are some instructions about your paperwork.

PLEASE READ AND SIGN ALL PAPERWORK

Please bring completed paperwork with you, and plan to stay **1 ½ - 2 hours**. Sometimes patient flow may make your stay longer.

Please bring your **insurance cards**, a **picture ID**, **co-pay/deductible**, and a list of your medications including dosage and how often the medications are taken.

Please make sure you have someone who can take you home.
Due to restrictions in the waiting area, your ride will be called to pick you up at discharge. You will be ready to go home in approximately 30 minutes after your procedure has finished.

We are **not** responsible for your lost or stolen articles. Please leave them at home or with your driver.

As a Medicare certified facility we have the duty to inform you of certain information prior to the date of your procedure. This information is contained in a document entitled *Patient Rights and Notification* which can be found in this packet, or on our website, www.tbirdendo.com. Please click on the heading "For Your Visit" and the link "Patient Forms."

If you do not have Internet access we will provide you with a paper copy of this information.

We look forward to seeing you.
If you have any questions, please call (602) 439-1717.
Thank you.

THUNDERBIRD
ENDOSCOPY CENTER

If you Need to Reschedule Your Procedure

When your procedure is scheduled at the Endoscopy Center,
We reserve that time especially for you.
It can often take weeks to get a procedure scheduled, due to
The limited availability of time in the center.
If you need to reschedule your procedure, please do so at
least 72 hours in advance.

This will allow other patients to use this time in the Endoscopy Center. Patients who do not give advance notice of cancelled procedures may not be rescheduled.

To cancel or reschedule a procedure,
please call (602) 843-1265.

***If your insurance changes prior to your procedure, please call the Endoscopy Center and the Physician's Office to make sure your procedure will still be covered.**

Thank you!! ☺

THUNDERBIRD
ENDOSCOPY CENTER

PROPOFOL PATIENT EDUCATION

Propofol is one of the most commonly used medications for inducing anesthesia (making patients sleepy) for procedures. It is safely administered thousands of times a day nationwide and produces a level of deep sedation for your procedure.

Deep Sedation: Propofol induced deep sedation is a deeper level of sedation in which you do not respond purposefully to repeated or painful stimuli. Potential complications of any sedation include: breathing problems (decreased respiration, aspiration leading to pneumonia, airway blockage), heart problems (low blood pressure or irregular rhythm), for which you will be monitored and treated if necessary.

Potential Propofol side effects that you should report right away to your physician include:

- Allergic reactions during anesthesia/sedation are uncommon and occur in about 1 out of every 10,000-20,000 cases. Signs or symptoms of an allergic reaction may include: itching or hives, swelling in your face or hands, swelling or tingling in your mouth, or throat, chest tightness, or trouble breathing

Other rare potential side effects may include:

- Decrease in how much you urinate
- Dizziness, lightheadedness, or fainting
- Fever, chills, cough, sore throat, body aches
- Lower back or side pain
- Pain or fullness in your upper stomach
- Seizures
- Slow, fast or uneven heartbeat.

Your CRNA (Certified Registered Nurse Anesthetist) can answer any of your questions regarding your planned sedation and anesthesia care.

THUNDERBIRD
ENDOSCOPY CENTER

PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	MIDDLE NAME	SEX MALE FEMALE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	HOME PHONE

ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	MOBILE PHONE

HOW DO YOU PREFER TO BE CONTACTED: HOME PHONE_____ MOBILE PHONE_____ EMAIL_____

OCCUPATION	EMPLOYED BY	BUSINESS PHONE
NAME OF SPOUSE	EMPLOYED BY	BUSINESS PHONE
IN CASE OF EMERGENCY: Notify	RELATIONSHIP TO PATIENT	PHONE

PRIMARY or REFERRING PHYSICIAN

PRIMARY INSURANCE

NAME OF INSURANCE_____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

SUBSCRIBER _____

RELATION TO PATIENT _____

SOCIAL SECURITY# _____DOB _____

POLICY # _____

GROUP # _____

EFFECTIVE DATE _____

SECONDARY INSURANCE

NAME OF INSURANCE_____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

SUBSCRIBER _____

RELATION TO PATIENT _____

SOCIAL SECURITY# _____DOB _____

POLICY # _____

GROUP # _____

EFFECTIVE DATE _____

CONSENT FOR RELEASE OF TREATMENT RECORDS/ INSURANCE AUTHORIZATION

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of Thunderbird Endoscopy Center. Transmittal by Fax is authorized. I hereby assign benefits to Thunderbird Endoscopy Center. I understand that payment is due as services are provided unless I have authorized insurance billing and I have been informed of the cost of the procedure I am having today. If, after 60 days, an insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our understanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account I/we agree to pay attorney's fees and court incurred for collection.

PATIENT'S SIGNATURE _____ DATE _____

MRN _____

THUNDERBIRD
ENDOSCOPY CENTER

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to _____Surgical Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at _____ Surgical Center may have an ownership interest in _____Surgical Center. I have been advised that I will be provided a list of physicians who have a financial interest or ownership in the Center upon request. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at _____Surgical Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the center is correct.

Email/Text/Automated Communication Informed Consent

I hereby consent and authorize [Center Name], any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature	Date Signed	Printed Name
Parent/Guardian Signature (if patient is a minor)	Date Signed	Printed Name

Contact Information:
Mobile Phone Number: _____Email address: _____

To revoke your consent to receive text messages or electronic mail from [Center Name], you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____	_____
Signature of Patient or Responsible Party	Print Name
_____	_____
Relationship to Patient	Date Signed

NOTICE OF PRIVACY PRACTICES

Thunderbird Endoscopy Center- 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.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Center Administrator (602) 439-1717

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement
_____Date:_____

Version 3.0 Effective Date: August 22, 2013

Westside Anesthesia Services Plc

For Anesthesia Services Offered at Thunderbird Endoscopy Center

Thunderbird Endoscopy Center offers state of the art advanced anesthesia services to its patients. Propofol is an IV drug administered by a Certified Registered Nurse Anesthetist (CRNA), who is highly trained and specialized to safely administer your sedation. Propofol has distinct advantages over other medications in that it generally produces a much deeper level of sedation, ensuring that you will be asleep and comfortable during the procedure, yet allowing you to wake up and recover much faster after the procedure is completed.

The CRNA will carefully deliver medications while monitoring your vital signs (pulse, blood pressure, respiratory rate, EKG rhythm strip, and pulse oximetry) during your procedure. Based upon your medical history and condition, your physician, nurse practitioner, or physician assistant will recommend that you have either Propofol administered by a CRNA or alternative forms of IV conscious sedation.

Please note that charge for anesthesia services (CRNA) are separate from and in addition to charges for endoscopic services rendered by your physician, the surgery center, and pathology charges (biopsies, if taken). These charges are generally covered by your health insurance policy. In the event that your insurance will not cover anesthesia (CRNA) administered Propofol IV sedation for your endoscopic procedure, alternative self-payment arrangements for this important services can be made with the billing department at 602-343-7954.

Non Coverage of anesthesia for services provided

_____(Initial Here) I agree to receive anesthesia services, as recommended by my physician / nurse practitioner / physician assistant, CRNA administered IV Propofol, and I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance.

_____ _____

Patient Signature Date

_____

Print Name

THUNDERBIRD
ENDOSCOPY CENTER

Patient's Rights and Notification of Physician Ownership

PATIENT RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care free from coercion, manipulation, sexual abuse and sexual assault.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patients' rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- To be informed of your right to change providers if other qualified providers are available.

PATIENT RESPONSIBILITIES:

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- To accept personal financial responsibility for any charges not covered by their insurance.
- To be respectful of healthcare personnel and staff, as well as other patients.

If you need an interpreter:

If you will need an interpreter, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Statement of Nondiscrimination:

Thunderbird Endoscopy Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Thunderbird Endoscopy Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Thunderbird Endoscopy Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Arizona Statute Title 36-3201 through 36-3210. Arizona statute defines a health care directive as a document drafted in compliance with statute "to deal with a person's future health care decisions". All adults have the fundamental right to control their own medical care. Arizona law recognizes three distinct types of documents which can be executed in advance to provide a mechanism for healthcare decision making when a patient is no longer able to make the decisions directly. These documents are the Health Care Powers of Attorney, Living Wills, and Pre-hospital Medical Care Directives.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Thunderbird Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this Center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the Center, the personnel at the Center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the Center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to Center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken. The following are the names and/or agencies you may contact:

Center Director

Thunderbird Endoscopy Center
Center Administrator
602-439-1717
5823 W. Eugie Ave, Suite B, Glendale, AZ 85304

State Agency

Arizona Department of Health Services
Attn: Bureau Chief
150 N. 18th Ave, Suite 450, Phoenix, AZ 85007
Phone: 602.364.3031 Fax: 602.364.4764
www.azdhs.gov

Medicare Ombudsman

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.
Medicare Ombudsman Web site:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
Medicare:
www.medicare.gov or call 1-800-633-4227
Office of the Inspector General: http://oig.hhs.gov

AAAHC

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
5250 Old Orchard Road, Suite 200, Skokie, IL 60077
Phone: 847-853-6060 or email: info@aaahc.org

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

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Steven Kanner, MD; Jodie Labowitz, MD; Mahesh Mokhashi, MD; James Singer, MD; Michael Yanish, MD; Mary Atia, MD.