Pelham Parkway
Surgery Center

1000 Pelham Parkway S ● Bronx, NY 10461
(718) 884-8660 ● (718) 884-8661 Fax
www.pelhamparkwaysc.com

Patient Arrival Time:_____

Patient Instruction Packet

Please read the information in this packet at least 5 DAYS prior to the time of your scheduled appointment.

Please complete pages 4 thru 7 and page 19 Bring this entire patient packet with you on the day of your appointment.

Please complete Page 8 ONLY if your procedure is related to an Injury / Accident.

Pelham Parkway Surgery Center
1000 Pelham Parkway South
Bronx, NY 10461
Tel: 718-884-8660
Fax: 718-884-8661
www.pelhamparkwaysc.com

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Please complete the forms on Pages 4 thru 7 and page 19, Bring the entire packet with you on the day of your appointment.

Please complete Page 8 <u>ONLY</u> if your procedure is related to an Injury / Accident.

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Welcome Notice

Welcome to Pelham Parkway Surgery Center (PPSC). Our mission is to provide high-quality ambulatory medical/surgical/ care and related services to our community, considerate of the specific needs of individual patients. The Center's mission is to serve all people in need of medical/surgical care and related services, regardless of age, color, race, creed, national origin, religion, gender, marital status, disability, payer source, or any other personal characteristic or qualification, including the ability to pay.

PPSC serves as a valuable health care resource, offering high-quality clinical care across several medical disciplines, including Gastroenterology, Orthopedics, Pain Management, Podiatry, and Vascular Surgery.

The Center is licensed by New York State as an Article 28 free-standing Ambulatory Surgery Center, is accredited by the Center for Medicare and Medicaid Services (CMS).

Our community-based physicians, surgeons, and staff endeavor to achieve excellence in patient care and take pride in serving the healthcare needs of our diverse and widespread community.
Our patients and their families have embraced the Center as an integral part of their community.

PPSC is committed to maintaining and exceeding national quality standards and is recognized as an innovative leader in the future of ambulatory surgery services for our community.

Further information on PPSC can be found on our website: www.pelhamparkwaysc.com.

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Patient Registration

Today's Date _____Date of Birth_____ Age _____ Gender M / F Marital Status S M W D

Patient Name _____
(First Name) (MI) (Last Name)

Address_____
(Street) (Apt#) (City) (State) (Zip Code) (County)

Home Phone _____Cell Phone_____ Alternate Phone_____ E-mail _____

Name of Spouse/Partner_____ Cell Phone_____Alternate Phone _____

Emergency Contact _____Telephone_____ Relationship _____

Name and Phone number of the person that will escort you upon discharge from the Center_____ (__) _____

Ethnicity – Do you consider yourself Hispanic/Latino? Y__ / N__ Declined_____Unavailable/Unknown_____PrimaryLanguage_____

Race: which category best describes your race? American Indian/Alaskan ____Native Asian _____ Black or African American _____ White _____

Declined _____ Other _____

Employer _____ Occupation _____ Work Phone _____

Address _____

****

Primary Doctor _____ Address _____ Telephone _____ Fax_____

Referring Doctor _____ Address_____ Telephone _____ Fax_____

Do you have any allergies? ☐ Yes ☐ No Allergies to Latex? ☐ Yes ☐ No Allergies to food? ☐ Yes ☐ No [Please list]

_____

Allergies to medications? ☐ Yes ☐ No [Please list drug names] _____

****

Primary Insurance Company Name _____ Hosp Medical Ins Phone # _____

Address _____Group #_____ ID # _____

Name of Insured _____ Date of Birth _____SS # _____ Relationship _____

Secondary Ins. Company Name _____ Hosp Medical Ins Phone # _____

Address _____Group #_____ ID # _____

Name of Insured _____ Date of Birth _____SS # _____ Relationship _____

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

Signature: _____ _____
(Signature of an insured or authorized person, legal guardian if minor) Date

****

Do You Have A Health Care Proxy No / Yes. If Yes, Type: _____Copy Provided? No/ Yes.
Do You Have A Living will? No / Yes. If yes, type: _____Copy Provided? No / Yes.

****

If an interpreter is necessary, please sign below indicating the patient understands and agrees to the terms herein.

Interpreter' s Signature: _____ Date_____

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PRE PROCEDURE QUESTIONAIRE/MEDICATION LIST

Name: _____ **Height**_____ **Weight**_____

CURRENT MEDICATIONS- Please list all current prescriptions, over-the-counter medications, including MAOI's, vitamins, and supplements.

Prescription Medications	Dosage/ Frequency	Date of Last Dose	Prescription Medications	Dosage/ Frequency	Date of Last Dose
			Over-the-Counter Vitamins or Herbal Supplement	**Dosage/ Frequency**	**Date of Last Dose**

ALLERGIES ❑ **No Allergies** ❑ Penicillin ❑ Sulfa ❑ Aspirin ❑ Iodine ❑ Latex ❑ Soy ❑ Eggs ❑ Other

If you have allergies, describe reaction(s):_____

MEDICAL HISTORY- Please ☒ all that apply:

☐	Acid Reflux	☐	Chronic lung disease	☐	Gout	☐	Kidney Infection	☐	Sleep Apnea
☐	Anemia	☐	Chronic sinusitis	☐	Heart attack	☐	Kidney Stones	☐	Stroke/paralysis
☐	Arthritis	☐	Cirrhosis of liver	☐	Heart failure	☐	Liver Disease	☐	(Tuberculosis)
☐	Asthma	☐	Thyroid disease	☐	Heart Murmur	☐	Lupus	☐	Ulcerative Colitis
☐	Bleeding disorder	☐	Colon cancer	☐	Hepatitis	☐	Multiple sclerosis	☐	Other:
☐	Blood clots	☐	Colon polyps	☐	Hiatal/Groin hernia	☐	Pancreatitis		
☐	Blood Transfusion	☐	Crohn's Disease	☐	High blood pressure	☐	Parkinson's disease		
☐	Cancer	☐	Diabetes	☐	HIV or AIDS	☐	Phlebitis		
☐	Chest pain/angina	☐	Diverticulitis	☐	Irregular heartbeat	☐	Polio		
☐	Chronic anxiety	☐	Emphysema	☐	Irritable bowel syndrome	☐	Radiation therapy		
☐	Chronic cough	☐	Glaucoma	☐	Kidney disease/failure	☐	Seizures		

SURGICAL HISTORY- Include all surgeries/procedures and dates. Please be specific. _____

Female Patients: When was your last menstrual cycle? _____/____/_____ Could you be pregnant? ❑ No ❑ Yes

CURRENT MEDICAL CONDITIONS

Do you use oxygen? ❑ No ❑ Yes
Are you taking any MAOIs? ❑ No ❑ Yes
Have you taken any prednisone or other steroids for your breathing in the last 3 months? ❑ No ❑ Yes
Have you had pneumonia or bronchitis required.
in the past 6 months? ❑ No ❑ Yes
Smoking history ❑ No ❑ Yes; _____packs/day for years Currently smoking? ❑ No ❑ Yes Alcohol
❑ No ❑ Yes; amount per day: _____
Do you have: loose/chipped/capped teeth? ❑ No ❑ Yes Bridges/dentures? ❑ No ❑ Yes
Trouble opening mouth or jaw clicking? ❑ No ❑ Yes

ANESTHESIA HISTORY

Have you ever had anesthesia? ❑ No ❑ Yes
Have you ever had a problem with anesthesia? ❑ No ❑ Yes
Has any member of your family had a problem with anesthesia? ❑ No ☐ Yes
❑ No Pre-procedure testing required.
❑ Pre-procedure testing

_____ _____ _____ _____
Reviewing Nurse Print Name | Signature | Time | Date

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UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: _____ Med. Rec. #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct the above-named medical facility, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Pelham Parkway Surgery Center, to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the release of all my medical records pertaining to that transfer or admission to Pelham Parkway Surgery Center.

X _____ _____

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above-named medical facility sufficient monies and/or benefits to which I may be entitled to government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

I, the undersigned, have insurance with and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

X _____ _____

Signature of Patient or Authorized Representative Date

CONSENT FOR LABORATORY BILLING

During the course of your procedure, it may be necessary for your physician to obtain and send tissue samples, blood samples or request another laboratory testing. New York State requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative.

Therefore, it is necessary for the Center to receive authorization from the Patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing services will go directly to you as the Patient. Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation.

[ ] Yes, I am giving the laboratory permission to bill my insurance company

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for the payment of services directly to the laboratory.

X _____ _____

Signature of Patient or Authorized Representative Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Title XVIII of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, or authorize such a physician organization to submit a claim to Medicare for payment to me.

X _____ _____

Signature of Patient or Authorized Representative Date

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*The signature of the patient must be obtained unless the patient is an Unemancipated minor under the age of 18 or is otherwise incompetent to sign.

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Notice of Participation in Health Insurance Plans

This notice discloses the Health Insurance plans with which Pelham Parkway Surgery Center is a participating provider. In accordance with New York Law, you have the right to receive this notice prior to the provision of non-emergency services by Pelham Parkway Surgery Center. Pelham Parkway Surgery Center is also affiliated with Montefiore Medical Center.

Health Insurance plans that Pelham Parkway Surgery Center participates in as a participating provider or as an in-network provider.

1. Medicaid
2. Medicare
3.
4.
5.
6.
7.
8.
9.
10.
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12.
13.
14.
15.
16.
17.
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21.
22.
23.
24.
25.

Please note that the Anesthesia and Laboratory services associated with Pelham Parkway Surgery Center also participate with and are in- network for the above-listed health insurance plans. If you have a specific question about anesthesia plan participation, please contact 718-884-8660. If you have a specific question about Pelham Parkway Surgery Center participation, please contact the Administrator, Hisham Elsherbiny at 718-884-8660 or helsherbiny@pelhamparkwaysc.com.

Receipt of Notice of the Health Insurance Plans with whom Pelham Parkway Surgery Center is a Participating Provider

This Notice of Participation in Health Insurance Plans provides information to you about the Health Insurance Plans that Pelham Parkway Surgery Center participates in. It also provides contact information for the Anesthesia and Laboratory service providers who are associated with Pelham Parkway Surgery Center so that you can determine if those providers participate in your health insurance plan.

By signing this form, you acknowledge that you have received our Notice of Participation in Health Insurance Plans.

_____
Name of Patient or Patient Representative

X_____
Signature of Patient or Patient Representative

_____
Date

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Patient Label

ASC ACCIDENT/ INJURY QUESTIONNAIRE

Please fill out this questionnaire **ONLY** if your procedure is related to an injury/ accident.

Due to regulatory changes as of October 1st, 2015, Pelham Parkway Surgery Center may require additional information regarding your visit. Please complete this questionnaire with as much detail as possible to accurately bill your insurance carrier.

No-Fault Carrier /Workers Compensation Board.

Please be advised that we may contact you about the questions on this page if we require additional information.

Thank you for your cooperation.

When did the Injury/Accident happen? (for example April 2015)

Where did the Injury/Accident happen? (for example: At home, At work*, on the street)
***If it happened at work, what do you do for a living? (for example / Construction Worker)**

How did the Injury/ Accident happen? (for example / I slipped on the wet floor)
What bodypart was injured? (for example/ Right Knee)

X. _____ _____

Signature of Patient or Patient Representative Date

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FINANCIAL POLICY

Your physician has chosen to perform your surgery(s) or procedure(s) at the Pelham Parkway Surgery Center (PPSC). PPSC is a freestanding Ambulatory Surgical Center [ASC] subject to New York State regulations. It is not associated with your doctor's office and has separate financial and billing policies and procedures.

PPSC will charge you for its facility services. **Please understand that you are responsible for paying your bill(s) in connection with your treatment at the time of registration.** You will also receive a separate bill from your physician for your surgical procedure, a separate bill from the anesthesiologist, and a separate bill for applicable laboratory services.

Your physicians, anesthesiologists, and laboratory charges are independent of the PPSC charge.

The following is a statement of our Financial Policy that we require you to read and sign prior to your treatment at PPSC.

While your physician may participate in your insurance plan, PPSC may or may not participate with your insurance plan. Prior to the date of your procedure, please verify the details of your insurance coverage with your insurance carrier. To further understand PPSC's policy, please review the following:

1) **If PPSC participates with your insurance plan,** the fees for your services will be billed to your insurance plan. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance at the time of your procedure. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.

2) **If PPSC does not participate with your insurance plan,** PPSC will bill your insurance plan. If you have out-of-network
coverage, your insurance plan may cover a part of this charge. You are responsible for the payment of your deductible and co-insurance as well as any unpaid balance and PPSC will bill you accordingly. If you have no out-of-network coverage,
you will receive a bill from PPSC for the facility fee and anesthesia fee. You are required to make payment arrangements
prior to your procedure.

3) **PPSC participates with the Medicare program.** If you have Medicare coverage, you will be responsible for payment of the deductible and the remaining 20 percent of the approved charge. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.

4) **Some insurance plans will send PPSC's facility payment directly to you.** If you receive the payment for the services you received at PPSC, you are responsible for forwarding the check directly to PPSC. It is your responsibility to ensure the Center is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting the payments to PPSC constitutes a breach of contract and PPSC will pursue all legal remedies available to it to obtain such payments.

5) **Return Check Fee.** If you make payment to the Center by check and it is returned by the bank for any reason, you will incur a fee of **$35.00.**

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PATIENT SELF-DETERMINATION ACT/ ADVANCE DIRECTIVES

Pelham Parkway Surgery Center supports each patient's right to develop an advance directive; the Center will not condition the provision of care or discriminate against an individual based on whether or not an advance directive has been executed; and will provide education for its staff, patients and the community, as applicable, related to the patient self-determination act/advance directives.

NOTICE OF LIMITATION - Pelham Parkway Surgery Center will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.

If you are interested you may request resource information regarding self-determination. The information includes:

- The description of state law prepared by the Department of Health, entitled "Planning In Advance For Your Medical Treatment".
- The pamphlet prepared by the Department of Health, entitled, "Appointing Your Health Care Agent
- New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding About CPR Do Not Resuscitate Orders (DNR)".

Our staff will inquire and document your present status concerning advance directives during the pre-procedure assessment in the medical record.

If you have executed an advance directive and have brought a copy, this copy will be filed in your medical record.

If copies are not immediately available, the types of advance directives and the name and address of the healthcare agent are obtained and documented in your medical record.

If you request additional information or wish to make an advance directive, the Center will supply you with appropriate information and direction.

The Center will comply with the health care decisions made in good faith by a health care agent to the same extent as decisions made by a competent adult.

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As a patient in a Clinic in New York State, you have the right, consistent with law, to:

1. Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin,
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 for off-hour emergency coverage;
5. Be informed of and receive an estimate of the charges for services, view a list of the 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 his/her physician information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed 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 his/her action;
10. Refuse to participate in experimental research;
11. Voice grievances and recommend 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 response, the patient may complain to the New York State Department of Health;
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 payment contract;
15. Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to http://www.health.ny.gov/publications/1449/section_1.htm#access; Access to Your Medical Records and Do I Have the Right to See My Medical Records?
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 is available from the center.
18. View a list of the health plans and the hospitals that the center participates with; and
19. Receive an estimate of the amount that you will be billed after services are rendered.

Office of the Medicare Beneficiary Ombudsman
Visit www.medicare.gov or call 1.800.MEDICARE (1.800.633.4227) or use www.hhs.gov/center/ombudsman New York State Department of Health's Metropolitan Area Regional Office (MARO) at 1.800.804.5447

Grievances or safety concerns about our outpatient facility should be referred to our Medical Director or Administrator, 718-884-8660

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As a patient in a Clinic in New York State, you have the right, consistent with law, to:

20. The Patient has the right to:
    A: Personal Privacy
    B: Receive Care in a Safe Setting
    C: Be Free From all forms of Abuse or Harassment
    D: If a Patient is Adjudged incompetent under Applicable State Laws by a Court of Proper Jurisdiction, the rights of the Patient are Exercised by the Person Appointed under State Law to Act on the Patient's Behalf.
21. Patients are informed of their right to Change providers if other qualified providers are available.
22. 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.

The Patient Has a Responsibility to:

1. Being considerate of other patients and personnel and for assisting in the control of noise and other distractions.

2. Respecting the property of others and the facility and abiding by no-smoking rules.

3. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.

4..Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.

5. Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses, and hospitalizations, medications, unexpected changes in the patient s condition or any other patient health matters.

6. Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and is responsible for the outcome.

7. Promptly fulfilling his or her financial obligations to the facility.

8. Payment to the facility for copies of the medical records the patient may request.

9. Identifying any patient safety concerns.

_____
Name of Patient or Patient Representative

X_____
Signature of Patient or Patient Representative

_____
Date

Office of the Medicare Beneficiary Ombudsman
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OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a healthcare facility in which the physician has a financial interest, New York State passed a law prohibiting the physician, with certain exceptions, from referring you for clinical laboratory, pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure will help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work.

Statutory authority; *Public health law, §238 a (10)*

The Following Physicians Are the Owners of The Center: None

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say 'no to your request, but we'll tell you why in writing within 60 days.

Request confidential communication

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say yes to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say no if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide a list. A year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any actions.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 718-884-8660
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privac y/hippa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, to others involved in your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example, if you are unconscious, we may go-ahead to share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Examples: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and researcher. We have to meet many conditions before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' comprehension, law enforcement, and other government requests

We can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such a military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us you can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information seewww.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp/html.

Changes to the Terms of Notice

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office, and on our website.

Other Instructions for Notice

- Effect date: November 1, 2025
- Privacy Official Hisham Elsherbiny, email helsherbiny@pelhamparkwaysc.com 718-884-8660.
- Pelham Parkway Surgery Center "We never market or sell personal information."

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PATIENT ESCORT POLICY

As a matter of patient safety, the Pelham Parkway Surgery Center enforces the New York State Ambulatory Surgical Center **requirement that all patients having a procedure in our facility have an escort,** that is, a companion, family member or friend, to accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888 943-8435) to arrange for a care partner to accompany you home from your procedure.

Please Note That Your Procedure Cannot Be Performed Unless Your Escort Is Verified.

Thank you for your cooperation.

PERSONAL POSSESSIONS POLICY

Pelham Parkway Surgery Center will provide you with a bag to store your possessions and this bag will remain with you through your stay at the Center. Surgery Patients will be assigned a private locker to safely store their personal belongings during the surgery.

Please **DO NOT** wear jewelry, **DO NOT** bring laptops, **DO NOT** bring iPods or any other valuables when you come to the Center.

Please note that Pelham Parkway Surgery Center assumes no responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.

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Patient Acknowledgment of Advance Notices

I hereby acknowledge receipt of the Center's **HIPAA Notices of Privacy Practices** and acknowledge that the Center may use and disclose my health information for the purposes of treatment, obtaining payment for services rendered and performing routine healthcare operations and services in the Center.

By signing below, I hereby acknowledge that I received written notice of the **Patient's Bill of Rights and Responsibilities** prior to the start of my procedure.

I hereby acknowledge that I received a written **Ownership Disclosure** listing the physicians who have financial interest or ownership in the ASC facility.

I hereby acknowledge that I was offered written information concerning **Advance Directives**.

I understand that I am **required** to bring an **Escort** to take me home on the day of the procedure.

I have received a copy of the **Financial Policy,** and I understand that I may be financially responsible for any outpatient facility charges, as outlined in my insurance coverage for copayments, coinsurance, and deductibles.

First Name: _____ M.I. _____

Last Name: _____

X _____

Signature Date

_____

Witness Date

_____

Interpreter Date

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Frequently Asked Questions (FAQ'S)

The following list of questions and answers may assist you in preparing for your procedure:

Q) Will my procedure be painful?
A) *You may have some discomfort, but the Center is fully staffed with Board-certified anesthesiologists to ensure that your procedure is comfortable.*

Q) What should I do to prepare for my procedure?
A) If you are receiving Anesthesia, you may not have anything to eat or drink (including water, candies, mint or gum) for eight (8) hours before your procedure. If you are on other medications for conditions such as diabetes or high blood pressure, please talk to your doctor about them before your procedure. Generally, you can take these types of medicines on the day of your procedure with a sip of water. If you are on an aspirin regimen or any other type of blood thinner, this medication should be stopped a few days prior to your procedure, as per the recommendation of your physician.

Q) How long will I be at the Center?
A) *Your stay at the Center is determined by the procedure/surgery. You will spend less time at the center by making certain you are punctual for your appointment. Arriving earlier than your appointment time won't necessarily get you through faster while arriving late will probably cause you to lose your scheduled time slot and create substantial delays for you. Completing the required paperwork (available on-line or by mail) prior to your arrival will expedite the process.*

Q) Do I have to bring an escort with me?
A) *Yes. The Center requires that you have an escort to take you home.*

Q) May I drive home?
A) N*o. Patients will not be allowed to drive after a procedure and must make necessary transportation arrangements. If you plan to walk or take public transportation from our facility after a procedure, please make sure you are accompanied by a responsible adult.*

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DIRECTIONS

Pelham Parkway Surgery Center
1000 Pelham Parkway South, Bronx, NY 10461

By Subway:

1) **Take the 2 or 5 train**: Board a 2 or 5 train heading towards the Bronx.
2) **Get off at Pelham Parkway Station**: Exit the train at the Pelham Parkway Station.
3) **Walk to your destination**: From the Pelham Parkway Station, it's a short walk to 1000 Pelham Parkway South.

By Bus:

1) **Take the Bx12 or Bx22 bus**: Board either the Bx12 or Bx22 bus heading towards Pelham Parkway.
2) **Get off at Pelham Parkway South**: Exit the bus at the Pelham Parkway South stop.
3) **Walk to your destination**: From the bus stop, it's a short walk to 1000 Pelham Parkway South.

By Car:

There is valet parking available for patient escorts or their family members (*Pending*)

From Manhattan

Via FDR Drive:

1) Head northeast on FDR Drive: Take the FDR Drive northbound.
2) Merge onto I-278 E: Follow signs for the Bronx/Queens.
3) Take the exit onto I-95 N: Follow signs for New Haven.
4) Take the Pelham Parkway exit: Follow the signs for Pelham Parkway.
5) Continue on Pelham Parkway: Drive along Pelham Parkway until you reach Pelham Parkway South.
6) Arrive at your destination: The Pelham Parkway Surgery Center will be on your right at 1000 Pelham Parkway South.

Via Manhattan Bridge:

1) Start from the Manhattan Bridge: Head northeast on the Manhattan Bridge.
2) Take NY-9A N: Continue on NY-9A N and follow signs for I-95 N.
3) Merge onto I-95 N: Take the exit toward Pelham Parkway.
4) Continue on Pelham Parkway: Drive along Pelham Parkway until you reach Pelham Parkway South.
5) Arrive at your destination: The Pelham Parkway Surgery Center will be on your right at 1000 Pelham Parkway South.

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From Queens & Long Island

From Queens via Throggs Neck Bridge:

1) Take the Throggs Neck Bridge and follow signs for the New England Thruway.
2) Take the Pelham Parkway West exit.
3) Proceed on Pelham Parkway for four traffic lights to Williamsbridge Road.
4) Turn right onto Williamsbridge Road and bear right immediately onto Esplanade.

From Queens via Whitestone Bridge:

1) Take the Whitestone Bridge and follow signs for the Hutchinson River Parkway.
2) Take the Pelham Parkway West exit.
3) Proceed on Pelham Parkway for four traffic lights to Williamsbridge Road.
4) Turn right onto Williamsbridge Road and bear right immediately onto Esplanade.

From Long Island:

1) Take the Long Island Expressway (I-495) west towards Queens.
2) Follow signs for the Throggs Neck Bridge or Whitestone Bridge and proceed as per the directions above.

From Westchester

1) Take the New England Thruway (I-95 S): Head south on I-95 S towards the Bronx.
2) Take the Pelham Parkway West exit: Follow the signs for Pelham Parkway West.
3) Continue on Pelham Parkway: Drive along Pelham Parkway for four traffic lights until you reach Williamsbridge Road.
4) Turn right onto Williamsbridge Road: Make a right turn onto Williamsbridge Road.
5) Bear right onto Esplanade: Immediately bear right at the fork onto Esplanade.
6) Arrive at your destination: The Pelham Parkway Surgery Center will be on your right at 1000 Pelham Parkway South

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PROCEDURE INFORMATION SHEET
GASTROENTEROLOGY

Upper endoscopy or **EGD (EsophagoGastroDuodenoscopy)** involves the insertion of a lighted flexible tube, called an upper endoscopy, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare but may require hospitalization, blood transfusions, or surgery.

A **colonoscopy** involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare but may require hospitalization, blood transfusions, or surgery.

Endoscopic Ultrasound, also known as EUS or Endosonography, is a specialized endoscopic study that enables your doctor to examine your stomach lining and the walls of your upper and lower gastrointestinal tract. EUS is also used to study internal organs next to the intestinal tract such as the Gall Bladder and Pancreas. The procedure is similar to routine endoscopy (EGD) or colonoscopy. A flexible tube is guided visually into the mouth or rectum. Then the EUS is used to scan and obtain ultrasound images. It is also possible to obtain tissue sampling via a fine needle aspirate (FNA) using real-time ultrasound guidance.
EUS is generally a safe procedure but carries several risks that include, but are not limited to, infection, perforation, and bleeding. Serious complications of EUS, such as perforation or bleeding, are rare but may require hospitalization, blood transfusions, or surgery.

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure, there are risks that may occur with any surgical or medical procedure.

There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

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PROCEDURE INFORMATION SHEET
ORTHOPEDICS

Arthroscopic Surgery is performed under general or regional anesthesia. After the anesthesia has taken effect, the patient's surgical site (i.e., arm or leg) will be cleaned with sterile technique to perform the surgery in a sterile fashion. A fiberoptic camera is inserted through a small incision or portal around the joint. The camera lens magnifies and projects the small structures in the joint onto a television monitor, allowing the surgeon to accurately diagnose the condition. Several other small portals are used to allow the surgeon to place the camera in different positions to see different structures inside the joint as well as to place various small instruments into the joint to help treat various problems. Sometimes arthroscopy is combined with open procedures. Once the procedure is completed, the instruments will be removed and a sterile bandage/splint will be placed.

Dupuytren's – this is usually done for bands of thickened tissue, which starts to pull the finger down towards the palm. The aim of the operation is to remove as much of the Dupuytren's tissue as possible and gain as much straightening of the finger or finger's as possible. Often full correction is not possible and your surgeon will discuss other options with you.

Carpal tunnel syndrome – this is where a nerve is trapped in the hand. This can cause tingling and numbness in the fingers. The aim of the operation (decompression) is to ease the tingling and numbness. If you have had your symptoms for a long time or you have had a lot of wasting of the thumb muscles and loss of strength and certain thumb movements this may take a long time to recover.

Removal of ganglion – is a collection of fluid in a sack that can involve the nerves. The aim of the operation is to try to remove the entire ganglion sometimes this is not possible because the nerves or a blood vessel are involved. It is possible for the ganglion to come back.

Removal of a lipoma – a lipoma is a fatty lump. These can sometimes come back.

Removal of a cyst – a cyst is a collection of fluid. These can sometimes come back.

Trigger finger release surgery - The surgery is usually done with local anesthetic or a nerve block. The surgeon will make a small cut into the skin to expose the flexor tendon sheath. The sheath is then released and the hand is bandaged. The bandage is removed within a few days and the finger can then begin to be used once again. The trigger finger release surgeon will often advise patients to exercise the finger to help prevent scar tissue from forming.

As with any surgery, orthopedic surgeries have risks. These include infection and potential damage to nerves and arteries, bleeding, infection, deep vein thrombosis (blood clots), incomplete relief of pain, need for further surgery, less motion (stiffness), heart attack, medical problems, and anesthetic risks. Stiffness may need to be addressed through post-operative rehabilitation. Preoperative sickness (such as diabetes, kidney disease or decreased blood flow) raises the chances of complications. Smoking is one of the biggest reasons for problems after surgery and increases the possibility of bone and tissues not healing appropriately.

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PROCEDURE INFORMATION SHEET
PAIN MANAGEMENT

Ultrasound-Guided Nerve Blocks and Regional Anesthesia - Our doctors use ultrasound to locate and guide therapeutic interventions for operative anesthesia or pain management. Our physicians are currently involved in multi-center trials that involve ultrasound-guided regional anesthesia. Regional anesthesia has been shown to decrease recovery time, and the need for opiate pain medication, as well as medication side effects (ex. nausea, vomiting). In some cases, it can even be used to avoid general anesthesia and intubation.

TAP Block - Transversus abdominis plane block is an abdominal wall nerve block that is performed using ultrasound guidance to help alleviate abdominal pain. It can be used to treat chronic abdominal pain, post-operative pain and/or cancer pain. Physicians use ultrasound guidance to perform this procedure to improve accuracy and minimize risks. The procedure can be performed as a procedure with anesthesia.

Celiac Plexus Block - Performed under X-Ray guidance to help alleviate and diagnose chronic abdominal and cancer related abdominal pain. The celiac block interrupts the pain signals from the abdomen to the brain, decreasing the discomfort of the patient and helps avoid the side effects of chronic opiate medications. The procedure is performed on an outpatient basis. The procedure can be repeated with alcohol to give longer relief. Typically the pain can be relieved for weeks to months with each injection.