HANOVER ENDOSCOPY CENTER
91 S JEFFERSON ROAD SUITE 300
WHIPPANY, NJ 07981

PLEASE FILL OUT THIS FORM AND BRING TO YOUR APPOINTMENT.
DO NOT MAIL TO OFFICE

PATIENT INFORMATION

PATIENT:_____AGE:_____DATE OF BIRTH:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP_____
HOME PHONE:_____MOBILE PHONE:_____
MARITAL STATUS:_____GENDER_____
EMAIL ADDRESS_____
HOW DO YOU PREFER TO BE CONTACTED: HOME PHONE:___MOBILE PHONE___EMAIL___
DO YOU RESIDE IN A SKILLED NURSING FACILITY?:_____
FAMILY /REFERRING PHYSICIAN INCLUDING FAX NUMBER_____
DO YOU HAVE A LIVING WILL?:__WOULD YOU LIKE INFORMATION ON LIVING WILLS___

PRIMARY INSURANCE INFORMATION

COMPANY:_____TELEPHONE_____
ADDRESS:_____CITY/STATE/ZIP:_____
MEMBER #_____GROUP#_____
NAME OF INSURED:_____INSURED SSN:_____
INSURED DATE OF BIRTH:_____RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE INFORMATION

COMPANY:_____TELEPHONE:_____
ADDRESS:_____CITY/STATE/ZIP:_____
MEMBER#_____GROUP #_____
NAME OF INSURED:_____INSURED SSN:_____
INSURED DATE OF BIRTH:_____RELATIONSHIP TO PATIENT:_____

EMPLOYMENT INFORMATION

EMPLOYER_____TELEPHONE_____
ADDRESS:_____CITY/STATE/ZIP_____
RELATION TO PATIENT:_____DATE OF INJURY:_____

EMERGENCY NOTIFICATION

CONTACT:_____TELEPHONE:_____
RELATIONSHIP:_____

_____ _____
SIGNATURE (PATIENT OR REPRESENTATIVE) DATE

HANOVER ENDOSCOPY CENTER - NOTICE OF PRIVACY PRACTICES

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 applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.

How We Use & Disclose Your PHI

Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care.

Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan.

Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it.

The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.

Other Uses and Disclosures We May Make

Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care.

Required by Law: We may disclose your PHI as required by law , such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law.

Research: We may use or disclose PHI for approved medical research.

Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises.

Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose PHI 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 PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes.

Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

De-identification. We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential.

Health information exchanges. We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.

In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.

If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.

We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with drafting notes or scheduling appointments.

Individual Rights

You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.

□ 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.

□ You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.

□ You have the right to request that we amend your PHI.

□ You may request a list of disclosures of PHI about you except for disclosures made with your authorization and 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 Duties/Changes to this Notice

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, 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 PHI.

We may change this Notice at any time and make the new terms effective for all PHI 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 Contact Person listed below.

Complaints/Contact Person

If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You may also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:

Center Privacy Officer (973-929-6800)

Patient Name: _____

Patient Signature: _____

Date: _____

Version 3.0

Effective Date: 12/31/2025

Hanover Endoscopy Center

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia 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, physician's office, anesthesia and/or pathology providers are 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. I am aware that I may receive a separate bill for any physician, anesthesia or pathology services performed from their respective companies

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to The Hanover Endoscopy 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 The Hanover Endoscopy Center may have an ownership interest in The Hanover Endoscopy Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. 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 Hanover Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my 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 the Hanover Endoscopy Center, 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 The Hanover Endoscopy Center , 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.

Do you have an Advanced Directive for healthcare? Yes or No (circle) If No, would you like any information? Yes or No (circle)
Did the patient bring a copy to the Center? Yes or No (circle) If provided, a copy is placed in patient's medical record.

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

I hereby authorize the The Hanover Endoscopy Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

My spouse/family member/other Name(s): _____ _____Initials

Leave a message on my answering machine: Yes_____ No_____ _____Initials

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

_____ _____
Signature of Patient or Responsible Party Print Name

_____ _____
Relationship to Patient Date Signed

REFERRING /PRIMARY PHYSICIAN

WHO IS YOUR PRIMARY PHYSICIAN?_____

ARE THERE ANY OTHER PHYSICIANS YOU WOULD LIKE TO GET A COPY OF TODAY'S REPORT? IF YES PLEASE LIST BELOW WITH FAX NUMBER TO ENSURE THAT THEY WILL RECEIVE THE REPORT

_____

_____

_____

CONTACT/TRANSPORT INFORMATION

Who is driving you home today? _____

Relationship_____

Will they be waiting in the waiting room? ☐ **Yes** ☐ **No**

Phone number

Home#_____

Cell#_____

Work#_____

For office use only

☐ **Spoke with driver**_____ **Left Message**_____

☐ **Spoke with MD**

Waiting: Rm 1 Rm2 chairs

HANOVER ENDOSCOPY CENTER

WHAT CAN YOU EXPECT ON THE DAY OF YOUR PROCEDURE

CHECK IN

You will have forms to fill out upon your arrival at the Endoscopy Center

Please have your insurance card and ID available

After completing your paperwork, you may have to wait for a short time before you are escorted into the preoperative area.

PREOPERATIVE AREA

In the preoperative area a nurse will confirm your procedure and physician.

We will have you change into a gown and help you get comfortable on the stretcher.

The nurse will go through a series of questions including your medical history and medications.

The nurse will start an intravenous line that will be used to administer your sedation during your procedure.

You will speak with your anesthesiologist who will explain the process of sedation for your procedure.

PROCEDURE ROOM

In the procedure room you will be attached to monitors. Your heart rate/rhythm, oxygenation and blood pressure will be monitored throughout the procedure.

Oxygen will be supplied via a small plastic cannula which is placed just inside your nose and will remain until you are awake in the Recovery Room.

Your physician will be available for any questions.

The procedure will take between 15 min and an hour depending on the procedure(s) you are having. You should not feel any discomfort during the procedure.

RECOVERY ROOM

You will spend approximately half an hour in the recovery room where they will continue to monitor your vital signs.

You will be offered a drink and after which your intravenous line will be removed.

Before you are discharged your physician will speak with you about your results. Any tissue samples will be sent for evaluation at a pathology lab.

You will be given written discharge instructions, and the nurse will go over those with you before you leave.

A phone number for your physician will be included in the discharge instructions so that you can reach him/her if need be.

You may feel groggy after the procedure due to the sedation. For this reason, it is required that you have a family member or friend pick you up after the procedure.

POST DISCHARGE

You will be called within 72 hours of your procedure by a member of our staff as a follow-up to your procedure.

Screening vs. Diagnostic vs. Surveillance Colonoscopy

In people **younger than 50**, colorectal cancer is now the leading cause of cancer-related deaths in men and the second in women. Getting screened is critical to detecting and preventing colorectal cancer. Timely screenings can save your life. A variety of different screening methods are available; however, a colonoscopy is the gold standard — the only screening method that can detect and prevent colorectal cancer. There are three different types of colonoscopy, with each one serving a different purpose. To better understand each one, an overview has been provided below.

Screening Colonoscopy

Screening colonoscopy is recommended starting at age 45 for individuals of average risk* of colorectal cancer. Average risk means that the person has no first-degree relatives including father, mother, child and/or siblings or personal history of colorectal cancer or polyps and no history of ulcerative colitis or Crohn's disease. The goal is to detect precancerous polyps or early cancer before symptoms arise. Procedure is done once every 10 years if the initial exam is normal and if the patient remains at average risk. **It is a preventive measure.**

Diagnostic Colonoscopy

Diagnostic Colonoscopy is recommended for patients with signs or symptoms consistent with colorectal cancer or to evaluate positive stool or blood-based screening tests. The purpose of investigating symptoms is to **diagnose any underlying conditions**, such as inflammatory bowel disease or cancer. Symptoms may include the following:

- **Bowel changes** — Diarrhea, constipation or a feeling that the bowel doesn't empty completely
- **Blood in stool** — Can be bright red or dark
- **Abdominal pain** — Abdominal pain, aches or cramps that do not go away
- **Weight loss** — Unexplained weight loss
- **Fatigue** — Feeling tired or weak
- **Other symptoms** — Frequent gas pains, bloating or abdominal fullness

Positive stool or blood-based screening tests must be evaluated with colonoscopy to exclude cancer or precancerous polyps.

Surveillance Colonoscopy

Surveillance Colonoscopy is recommended for patients if **they have had polyps removed in the past** or after **they have been treated** for colorectal cancer. Surveillance Colonoscopy may also be considered for those with ulcerative colitis or Crohn's disease, requiring more frequent checks than 10 years.

Paying For Your Colonoscopy

Screening Colonoscopy	Diagnostic/ Surveillance Colonoscopy
• May be covered at 100%*	• **MAY NOT** be covered at 100%*
IF	***WHEN***
• You are 45 years or older.	• Polyps are found and removed during a screening colonoscopy.
• No polyps are removed during the procedure. (Although most plans will still cover with appropriate insurance plan modifiers.)	• Polyps are removed during a surveillance colonoscopy.
• Procedure is done once every 10 years if the initial exam is normal and if the patient remains at average risk.	• Procedure is done more frequently than once every 10 years in a patient without previous CRC or polyps.
	• You may receive a bill from your surgery center or Anesthesia provider for your cost share based on your plan benefits.

*NOTE: Because insurance plans and coverage can differ, we recommend patients check with their health insurance carrier to determine if there will be any costs incurred with their screening, diagnostic or surveillance exams.