

Patient Instruction Packet Abridged



William Erber, M.D., P.C.

William Erber, M.D., P.C.
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www.drerber.com

Welcome Letter

Dear Patients:

Our Physicians and Staff at William Erber, M.D., P.C. would like to take this opportunity to welcome you to our office. As your providers of health care, we look forward to serving you. We hope that together, we can build the kind of relationship that will ensure that you receive quality of care and good service.

In order to get the most from your visit, it is very important that you familiarize yourself with the systems, policies, and benefits outlined in this letter or ask our staff if you have any further questions. Failure to follow the system and unfamiliarity with your benefits coverage may result in delays in receiving necessary health care and in unnecessary costs to you.

The following is important information you should know.

HOURS OF OPERATION

Office hours are Monday - Friday.

9:00 AM - 6:00 PM.

Early morning, evening, and weekend appointments are available on select dates.

Same day appointments and emergencies are always accommodated.

After hours calls will be directed to our Doctor's service.

Telephone: 718.972.8500

Fax: 718.972.0064

SCHEDULING APPOINTMENTS

Our appointment desk may be reached at 718.972.8500 from 9:00 AM - 5:00 PM

Monday - Friday. Be sure to identify yourself.

If you need to cancel an appointment, please call us AS SOON AS POSSIBLE.

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. If you have any questions of this notice, please contact our Privacy Officer, Susan Sagiv.

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

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any new revised Notice of Privacy Practices.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office and are involved in your care and treatment for the purpose of providing health care services to you. Your Protected Health Information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

TREATMENT: We will use and disclose your Protected Health Information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information.

In addition, we may disclose your Protected Health Information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physicians.

PAYMENT: Your Protected Health Information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care we recommended for you.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and conducting or arranging for other business activities. We will share your Protected Health Information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of your Protected Health Information will be made only with your written authorization, unless otherwise permitted or required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: We may use and disclose your Protected Health Information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are not present or able to agree or object to the use or disclosure of the Protected Health Information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the Protected Health Information that is relevant to your health care will be disclosed.

A. OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your Protected Health Information that directly relates to that persons involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, of your location, general condition, or death. We may use or disclose your Protected Health Information in an emergency treatment situation. We may use and disclose your Protected Health Information if your physician or another physician in the practice attempts to obtain consent from you, but is unable to do so due to substantial communication barriers.

B. We may also disclose your Protected Health Information in the following ways: As required by law; Public Health; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates. Requires Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Resources to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your Protected Health Information.
- You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your request should be in writing.
- Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information will not be restricted.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.
- You may have the right to have your physician amend and modify your Protected Health Information. This means you may request an amendment of Protected Health Information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment.
- You have the right to receive an accounting of certain disclosures except for treatment, payment, or healthcare operations.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Susan Sagiv, at 718.972.8500, for further information about the complaint process.

This notice was published and becomes effective on January 6, 2003.

PATIENTS' RIGHTS & RESPONSIBILITIES

YOU HAVE CERTAIN RIGHTS

1. You have the right to be treated with respect, consideration and dignity.
2. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis.
6. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages and disadvantages of each including the advantages or disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives mentioned in #7, above have been discussed with you.

10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know all of your rights as outlined above.
12. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
13. You have the right to know the services available at the facility.
14. You have the right to know the provisions for after-hours and emergency care.
15. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
16. You have the right to know whether or not your providers are insured.
17. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals in the event that you are dissatisfied with your treatment.
18. You have the right to know the name of your provider.
19. You have the right to know what fees are expected and what the payment policies are.
20. You have the right to know what your provider's credentials are.
21. You have the right to change providers.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need including any medications you are taking.
2. You have the responsibility to follow the directions of the nurse or physician with regard to diet and/or medication.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to your nurse or physician.
4. You have the responsibility to abstain from the use of alcohol as directed by your nurse or physician.
5. You have the responsibility to inform the nurse or physician if you do not understand any directions or you do not understand the course of treatment planned for you.
6. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

GET INVOLVED IN YOUR HEALTHCARE

Everyone has a role in making healthcare safe. Our Physicians, Nurses and Technicians are working to make your health care safety a priority. You as a patient can play a vital role in making your care safe by becoming an active, involved and informed member of your healthcare team. So **SPEAK UP!**

S – Speak Up if you have any questions or concerns and if you don't understand ask again

P – Pay Attention to the care you are receiving. Make sure you are getting the right treatment and Medication

E – Educate yourself about your diagnosis and your treatment plan

A – Ask a trusted family member to be your advocate

K – Know what medications you take and why you take them

U – Use a healthcare facility that provides quality care

P – Participate in all decisions about your treatment

PAIN

Pain is considered to be the fifth vital sign. We as your healthcare provider would like to assist you with any pain you might possibly have. Prompt, appropriate treatment of pain facilitates a successful physical exam and enhances your ability to undergo any tests that might be necessary to make an accurate

diagnosis. Please see the pain scale below to determine the quality and intensity of your pain and let us know.



ESCORT POLICY

All patients having a procedure in our Office Based Surgery Center must have an escort, that is, a companion, family member or friend, to accompany you home following your procedure. Alternatively, ambulance service can be arranged for you as well. **Please note that your procedure cannot be performed unless your escort home is verified.**

PERSONAL POSSESSIONS NOTICE

We will provide you with a secure private area to safely keep your personal belongings during your procedure. Please do not bring jewelry, laptops, iPods or any other valuables when you come to the Center unless absolutely necessary. Please note that William Erber, M.D., P.C. assumes no responsibility for lost, stolen, or misplaced items.

COMPLAINT RESOLUTION

We at William Erber, M.D., P.C. strive to provide you with excellent quality of care. We highly believe in changes to improve, and welcome an opportunity to listen to your suggestions and complaints. Please contact our Practice Manager or the Medical Director to get further information on our complaint resolution policy. We encourage you and your family to contact us if you have concerns about patient care and safety. If your concern is unresolved, you may contact the Joint Commission at: 800.994.6610.

BILLING & PAYMENT

Please see our scheduler for a list of insurances we accept. Your payment is due at the time services are rendered. Your co-payment is also due at time of services rendered.

PHYSICIAN INFORMATION

Your Physicians are Board Certified in Gastroenterology and Anesthesiology.

Becoming a licensed, board certified physician means meeting the most rigorous training and continuing education offered in the field of medicine.

Certification of physicians is done by medical specialty boards, recognized by the American Medical Association (AMA) and the American Board of Medical Specialties (ABMS), as a way to tell consumers that the doctors with this credential have successfully completed approved training and have passed an evaluation process assessing their ability to provide quality patient care in their specialty.

Board certification is time-limited, and to maintain their certification, doctors are periodically reevaluated. They must present evidence of licensure and scope of their practice and pass an examination every 7 to 10 years, depending on the specialty.

Board certification is a good indication that your doctor has made a commitment to continuing education and is keeping up with the latest findings in his or her field.

William Erber, MD, Gastroenterology

Medical Education: Chicago Medical School
Internship: Maimonides Medical Center
Residency: Maimonides Medical Center
Fellowship: Einstein Hospital, Albert Einstein College of Medicine

Jonathan Erber, MD, Gastroenterology

Medical Education: Tel Aviv University, Sackler Faculty of Medicine
Internship: Montefiore Medical Center, Albert Einstein College of Medicine
Residency: Montefiore Medical Center, Albert Einstein College of Medicine
Fellowship: SUNY Downstate Medical Center

Donald Baldwin, MD, Anesthesiology

Medical Education: Autonomous University of Guadalajara, Rush Medical College
Internship: Brookdale University Hospital
Residency: Montefiore Medical Center, Albert Einstein College of Medicine
Fellowship: Einstein Hospital, Albert Einstein College of Medicine

OWNERSHIP DISCLOSURE

William Erber, M.D., P.C. is owned and operated by Dr. William Erber.

Please keep this letter for future reference. Should you have any questions, feel free to call us at 718.972.8500. We look forward to serving you.

Sincerely,

William F. Erber, M.D.
Medical Director

Date: _____

I, the undersigned acknowledge that I have received the following disclosures from the practice.

- Practice Information
- Patients' Rights & Responsibilities
- Get Involved in Your Healthcare
- Information on Pain Assessment
- Escort Policy
- Personal Possessions Notice
- Complaint Resolution Policy
- Billing Information
- Physician(s) Qualification
- Ownership Disclosure

Name: _____

Signature: _____

Date: _____

For the patient's personal protection, the state of New York requires that each patient acknowledge in writing that they have received a copy of William Erber, M.D., P.C.'s Notice of Privacy Practices.

By signing below, I hereby acknowledge receipt of William Erber, M.D., P.C.'s Notice of Privacy Practices. I acknowledge that the Practice may use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and performing routine healthcare operations and services in the Practice.

Name: _____

Signature: _____