MEDICAL REGISTRATION AND HISTORY FORM

Name of Primary Care Physician (PCP) _____ PCP Phone # _____

Name of Referring Physician? _____ Phone # of Referring MD _____

Reason for your visit? ❑ bleeding ❑ colonoscopy ❑ constipation ❑ hemorrhoids ❑ itching ❑ pain - anal ❑ pain - abdominal ❑ warts

❑ other _____

PATIENT INFORMATION

Social Security # (All digits required for scheduling) _____-_____-_____

Patient Name:

_____

Last First Middle Initial

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

Ethnicity: ❑ Asian ❑ African Am. ❑ Hispanic/Latino ❑ White Other _____

❑ Married/Partnered ❑ Widowed ❑ Single ❑ Separated/Divorced

Spouse/Partner name _____

Spouse/Partner Birthdate _____

Patient Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____)_____

PHONE NUMBERS

Home (_____)_____ Cell (_____)_____

Best time and place to reach you _____

May we leave detailed messages? ❑ No ❑ Yes (❑ at home ❑ on cell)

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (_____)_____ Work (_____)_____

INSURANCE

Who is responsible for this account _____

Relationship to Patient _____

Primary Insurance Co _____

Group # _____ ID # _____

Is patient covered by additional (secondary) insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Insurance Co _____

Group # _____ ID # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

name of insurance company(ies)

and assign directly to ATL Colorectal Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

signature of beneficiary, guardian or personal representative date

_____

please print name of beneficiary, guardian or personal representative relationship to beneficiary

MEDICARE/MEDIGAP AUTHORIZATION ONLY ❑ NOT APPLICABLE

I request that payment of authorized Medicare benefits and , if applicable, Medigap benefits, be made either to me or on my behalf to

_____

name of doctor or clinic

for any services furnished to me by that provider.

To the extent permitted by law. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____

signature print name

FAMILY HISTORY	Age(s)	Alive Y/N	Cancer Y/N (specify)	Colon Polyps Y/N	Cause of Death
MOTHER					
FATHER					
SIBLINGS					
CHILDREN					

HEALTH HISTORY - Please check (✔) symptoms you currently have or have had in the past.

HEMATOLOGY:
❑ coumadin use
❑ aspirin use
❑ hypercoagulable state
❑ DVT/blood clots
❑ bleeding gums
❑ easy bleeding
❑ easy bruising
❑ anemia
❑ varicose veins

CONSTITUTIONAL:
❑ chills
❑ fever
❑ weakness
❑ fatigue
❑ weight change: loss/gain
❑ loss of appetite
❑ cancer (location _____)

DERMATOLOGY:
❑ itching
❑ psoriasis
❑ rashes
❑ moles - requiring removal
❑ eczema
❑ hives
❑ keloid formation
❑ skin cancer

MUSCULOSKELETAL:
❑ back pain
❑ muscle aches
❑ osteoarthritis
❑ rheumatoid arthritis
❑ muscle weakness
❑ joint pain/swelling
❑ sciatica
❑ osteopenia
❑ broken bones requiring surgery
❑ carpal tunnel syndrome

ENDOCRINOLOGY:
❑ thyroid disease
❑ diabetes
❑ polyuria (excessive urination)
❑ weight loss

NEUROLOGY:
❑ strokes
❑ migraines
❑ vertigo
❑ headache
❑ tingling/numbness
❑ seizures
❑ insomnia
❑ memory loss
❑ dizziness

OPHTHALMOLOGY:
❑ cataracts
❑ glaucoma
❑ nearsighted
❑ farsighted
❑ wear glasses
❑ wear contacts
❑ loss of vision

ENT/RESPIRATORY:
❑ shortness of breath
❑ pneumonia
❑ asthma
❑ emphysema
❑ tuberculosis exposure
❑ COPD
❑ hay fever
❑ cough
❑ bloody noses
❑ sore throat

CARDIOLOGY:
❑ chest pain
❑ hypercholesterolemia
❑ irregular heartbeat
❑ high blood pressure
❑ low blood pressure
❑ atrial fibrillation
❑ poor circulation
❑ murmurs
❑ palpitations
❑ dizziness
❑ mitral valve prolapse
❑ heart attack _____ (dates)
❑ stents placed _____ (date)
❑ aspirin use

GASTROENTEROLOGY:
❑ incontinence of stools
❑ peptic ulcer disease
❑ hiatal hernia
❑ incontinence of gas
❑ changes in stool size or texture
❑ bloating
❑ rectal bleeding
❑ anal fissure
❑ hemorrhoids
❑ excessive gas
❑ nausea
❑ heartburn or reflux
❑ vomiting
❑ difficulty swallowing
❑ irritable bowel syndrome
❑ abdominal pain
❑ diarrhea
❑ constipation
❑ change in bowel habits
❑ blood in stool
❑ colon polyps
❑ diverticulosis
❑ last colonoscopy date: _____

PSYCHOLOGY:
❑ depression
❑ tension/stress
❑ ADHD
❑ anxiety

GENITOURINARY MALE:
❑ abnormal anal PAP smear
❑ erectile dysfunction
❑ benign prostatic hypertrophy
❑ prostate cancer
❑ history of radiation
❑ urinary incontinence
❑ kidney stones
❑ difficulty urinating
❑ increased urinary frequency
❑ hernias
❑ kidney disease
❑ renal failure

GENITOURINARY FEMALE:
❑ urinary incontinence
❑ # of vaginal childbirths _____
❑ # of episiotomies/ vaginal tears ____
❑ # of vacuum/ forceps deliveries ____
❑ renal failure
❑ kidney disease
❑ kidney stones
❑ fibroid uterus
❑ ovarian cyst
❑ endometriosis
❑ rectocele
❑ increased urinary frequency
❑ pelvic pain
❑ abnormal PAP smear
❑ last mammogram date: _____

INFECTIOUS DISEASE:
❑ chlamydia
❑ genital warts
❑ herpes
❑ HIV
❑ HPV (Human Papilloma Virus)
❑ syphilis
❑ gonorrhea

Height ___ ' ___ " Weight _____ lb.

List prior surgeries & year performed:

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS / ALLERGIES

Current medications with dosages you are taking:

_____

_____

_____

List allergies to medications or substances:

_____

Pharmacy Name _____ Phone (_____)_____

HEALTH HABITS

check (✔) which you use and how much:

❑ Caffeine _____

❑ Street Drugs _____

Current Tobacco Use:
❑ cigarettes ❑ cigars ❑ pipe ❑ chew

packs per day _____ # of years _____

Former smoker, year quit _____

SIGNATURES

I have received both the ATL Colorectal Surgery P.C. Policy & Procedures statement and the Policy for Access & Denial of Patient Request for Protected Health Information. I have been provided an opportunity to review them. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or insurance status.

_____ _____
signature of beneficiary, guardian or personal representative date

_____ _____
please print name of beneficiary, guardian or personal representative relationship to beneficiary

ATL Colorectal Surgery, P.C. welcomes you to its family of physicians and healthcare providers. We are pleased you have selected ATL Colorectal Surgery, P.C. to provide you medical care. Our goal is to provide consistent high-quality colon and rectal health care. This Policy and Procedures statement is intended to address questions you may have with regard to services rendered at our facilities or in the hospital setting by members of the clinic. Your questions and comments are welcomed. We look forward to a longstanding relationship with you consistent with these policies and procedures. We require all of our patients to read and sign the acknowledgment set forth below which we will maintain in your medical file. Failure to adhere to these policies may result in your dismissal from the practice. However, we look forward to a long and healthy relationship with you as our patient.

Business Hours/After-Hours/Weekends: Our office is open Monday through Friday from 8:30 a.m. to 5:00 p.m. After hours urgent or emergency messages can be left with the answering service by calling our usual telephone number, 404-574-5820. In order to receive a call from the on-call physician, you must disable your caller ID.

Appointments for Minors: Patients under the age of 18 who are not married or emancipated and who seek medical treatment for problems must have written consent of a parent, guardian or custodian and may require a co-signor in order to receive medical treatment.

Cancellations/Missed Appointments/Re-Scheduled Appointments: ATL Colorectal Surgery, P.C. endeavors to provide services to our patients at their scheduled appointment time. Your office appointment has been scheduled at your request and the allotted time has been reserved especially for you and your needs. We have reserved examination space, medical personnel, medical equipment and medical supplies for your visit. Therefore, a 48-hour advance notice is required for re-scheduling and/or for cancellations of office appointments. Failure to notify our office more than 48 hours in advance will result in a charge of $30.00, which is not covered by your insurance and is your responsibility to pay. If you arrive late for your appointment and this affects the next appointment, you may need to be rescheduled. If you are scheduled for surgery or colonoscopy, and fail to cancel more than five (5) calendar days before the procedure date, you will be charged $200.00, which is not covered by your insurance. Excessive abuse of scheduled appointments may result in discharge from the clinic.

Treatment Plan and Termination: Patients of ATL Colorectal Surgery, P.C. may establish a specific plan of treatment under the care and advice of their physician and with that physician's consultation. Your refusal to comply with your recommended treatment plan or the existence of a less than optimal physician-patient relationship or relationship with members of the medical staff may result in discharge from the clinic. However, we will never terminate our relationship during an emergency medical care situation, due solely to a diagnosis of any disease or condition, or merely because insurance coverage has been dropped.

Prescription refill requests: Prescription refills are done during normal business hours. Please do not wait until you are out of your medication. Refill requests will not be filled if you are overdue for an appointment or owe a significant balance on your account unless satisfactory arrangements are made with the Office Manager in advance. Please be sure to have the name and dosage of your medication as well as the pharmacy telephone number. Please check with the pharmacy to see if your prescription has been filled. ATL Colorectal Surgery, P.C. reserves the right to dismiss a patient making repeated demands for habit-forming drugs.

Copies of Medical Records: Medical records remain in the custody and control of the physician. Upon written consent, copies can be made and supplied to you or to whom you designate. You authorize us to include all information including your billing and payment history. Our office charges for copying medical records according to Georgia State Law guidelines. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all information included in your file.

Payment for Services: For your convenience, we accept cash, VISA, MasterCard, American Express, and personal checks with valid picture ID. If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered. Unless other arrangements are approved by our practice in writing, the balance on your statement is due and payable when the statement is issued, is past due if not paid within thirty days, and is subject to finance charges. If it is necessary for you to make payment arrangements at any time, please contact our business office at (404) 574-5820. It is specifically not our intent to ever have finances prevent you from getting the very best of medical care. If payment of our fees ever presents a problem, please discuss the matter with the Office Manager.

Self-Pay Patients: ATL Colorectal Surgery, P.C. welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the Office Manager in advance of your visit to determine if a reasonable payment arrangement can be established between us.

Your medical insurance coverage: In order to accommodate the needs of our patients we have enrolled in numerous managed care insurance programs. Although we endeavor to maintain a current understanding of the insurance coverage provided by each insurance company, you are always in a better position than we are to ascertain the terms, conditions and limitations of your own insurance policy. Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. We have no control over the terms of your insurance contract, and questions regarding your coverage should be addressed to your employer, insurance agent and/or your insurance company. You agree to pay any portion of the charges not covered by your insurance.

Prior to your initial visit with your physician, please confirm that he or she participates in and is a member of your personal insurance network by reviewing the insurance literature provided with your policy of medical insurance or by contacting your insurance agent, employer or insurance company. If the physician does not participate with your insurance plan, you may be responsible for payment of out-of-network charges, or all charges at the time of your visit. You will be provided a completed superbill listing all the pertinent information you will need to submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information: If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurance, or services that are not covered by your plan. For ATL Colorectal Surgery, P.C. to file your insurance claim, we must have the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. Please bring your insurance card to each visit so that we can confirm your coverage. A current copy of your card must be kept on file in order for us to file insurance claims on your behalf. If your submitted demographics are incomplete or incorrect at the time of registration and this leads to a denial of payment, you may be responsible for full payment of your bill.

Initials _____ Date _____

You may be asked to verify your current insurance coverage, sign a release of information, an assignment of benefits, and present your insurance cards at each visit. If you arrive without your current insurance card, we will be happy to reschedule your appointment. If you wish to be seen without your insurance card, you will be required to pay for the visit in full that day; you will not receive any insurance discounts or adjustments. You can request reimbursement directly from your insurance company, but you will not receive the entire amount that you paid us.

You are financially responsible for certain charges at the time of EACH office visit. You may be responsible for any, or all, of the following items:

1. **Co-Pay:** This is a set dollar amount (usually between $5 - $50) or a percentage (usually 10 -25% of total charges) that you are REQUIRED to pay at EACH office visit. Under your contract, your plan has required that you pay a portion of the discounted amount they pay us at the time services are rendered to you. This amount is called your co-payment. Your co-payment is not paid in addition to, but instead is subtracted from the fee your insurance company pays to us. Therefore, it has become necessary for us to adopt a policy to collect your co-payment at the time services are rendered. We are unable to bill you for your co-payment, as this further increases our expenses and is also in violation with your managed care plan requirements.
2. **Deductible:** Some plans require that you pay a certain dollar amount (a "deductible") before your insurance company will cover any medical expense.
3. **Co-Insurance:** This is the percentage of charges that you pay in addition to any deductible. For example, if insurance pays 80%, then you pay 20%. This amount will be collected at your visit.

Patient Payment Responsibility for Non-Covered Services: In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. For this reason, we can provide you a form letter to complete by contacting your insurance plan and verifying the specific coverage you have prior to your preventive health visit. We may request payment for any known, non-covered services at the time of your visit: otherwise they will be billed to you at a later date.

Managed Care: If you are enrolled in a managed care insurance plan (i.e., HMO), you must obtain any necessary referrals for our office before seeing the physician. You are responsible for obtaining any referral and/or preauthorization for services should your insurance company require them. Failure to obtain the referral and/or pre-authorization may result in a denial of payment from your insurance company. If your insurance company requires a referral and/or pre-authorization and you do not have one, you may not be seen for your scheduled appointment, or you will be responsible for full payment of your bill at the time of service.

Medicare Patients: Your physician accepts Medicare assignment on covered Medicare charges. Payment for the 20% Medicare coinsurance amount, deductible, or any non-covered charges is expected at the time of service, unless you have supplemental insurance. Insurance will be filed with your supplemental carrier; however, any unpaid balances are expected to be paid by you within 60 days of filing the claim if the supplemental policy does not pay the clinic.

Surgery/Procedure Charges: If a procedure or surgery is scheduled, we will file your insurance claim and accept assignment on your behalf. However, you will be responsible for payment of any deductible, coinsurance and non-covered charges PRIOR TO entering the hospital. If the determined deductible or coinsurance is not paid within 7 calendar days prior to your surgery/procedure, the surgery/procedure may be cancelled or rescheduled.

A period of 60 days will be allowed for your insurance company to pay your claim. After that time, we will look to you for payment. We therefore ask that you contact your insurance company 45 days after your surgery to assist in obtaining payment on your behalf. After we receive payment from your insurance company, we will notify you of any remaining charges not covered by your plan. Payment in full will be due within 30 days of receiving this notification. Any credit due to you will be promptly refunded.

Finance Charge: A finance charge will be imposed on each item of your account that has not been paid within thirty (30) days of the time the item or service was added to the account. The FINANCE CHARGE will be computed at the rate of two percent (2%) per month or an ANNUAL PERCENTAGE RATE of twenty-four percent (24%). The finance charge on your account is computed by applying the periodic rate (2%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

Returned Checks: There is a fee [currently thirty dollars ($30)] for any checks returned by the bank. If your check is returned by the bank, we will no longer accept checks from you for payment. We will accept Cash, Visa, Mastercard, and American Express cards.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred and may include charges up to 50% of the bill. If we have to refer collection of the balance to a lawyer, you agree to pay all attorney fees that we incur including all court costs. If we have to refer your account to a collection agency, you will automatically be dismissed from our practice and have emergency services available to you for thirty days.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if the past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

We appreciate the confidence you have placed in choosing our practice for your colon and rectal care. During our association if you have any suggestions, questions, criticisms, or comments, or if you just want to thank us, please let us know. Please feel free to report to us any complaint that you have about our office. We will do our best to correct it. Above all, we are here to serve you with the finest medical care possible. Please help us to help you.

I have read and understand the ATL Colorectal Surgery, P.C. Policy and Procedures. I agree to assign insurance benefits to ATL Colorectal Surgery, P.C. whenever necessary.

_____	_____	_____
Signature of patient or responsible party	Print Name of patient or responsible party	Date

Policy For Access and Denial of Patient Request for PHI

Purpose

The purpose of this policy is to explain the procedures involved in a patient's right to access their protected health information (PHI) and the procedures involved for denial of such requests, and responses to such denials.

Policy

The access and denial process is managed by the office manager or custodian of the medical record. Patients have a right to inspect and receive a copy, at their expense, of the protected health information (PHI) in their designated record set. Exceptions to this include: psychotherapy notes, information compiled in anticipation of or use in a civil, criminal, or administration action or proceeding, and protected health information (PHI) subject to the Clinical Laboratory Improvements Amendments (CLIA) of 1988.

All workforce members must strictly observe the following standards:

ACCESS TO PHI PROCEDURE

1. A patient has the right to inspect, or receive copies of PHI about the patient in a designated record set for as long as the PHI is maintained in the designated record set.

2. If ATL Colorectal Surgery, P.C. does not maintain the PHI that is the subject of the patient's request for access, and ATL Colorectal Surgery, P.C. knows where the requested information is maintained, ATL Colorectal Surgery, P.C. must inform the patient where to direct the request for access.

3. The patient must make the request in writing.

4. ATL Colorectal Surgery, P.C. must act on the patient's request no later than the 30th business day after receipt and payment of the request. ATL Colorectal Surgery, P.C. shall:

a) make the information available, in full or in part, for examination; or inform the authorized requestor if the information does not exist, cannot be found, or is not yet complete. Upon completion or location of the information, ATL Colorectal Surgery, P.C. will notify the patient.

b) If the access is granted, in whole or in part, ATL Colorectal Surgery, P.C. must comply with the following requirements:

- ATL Colorectal Surgery, P.C. must provide the patient access to his/her PHI in the designated record sets, including inspection or receiving a copy, or both. If the same PHI that is the subject of a request for access is maintained in more than one designated record set or at more than one location, ATL Colorectal Surgery, P.C. need only produce the PHI once in response to a request for access.
- ATL Colorectal Surgery, P.C. must provide the patient with access to the PHI in the form or format requested by the patient, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by both parties.

ATL Colorectal Surgery, P.C. may provide the patient with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided, if:

A. The patient agrees in advance to such a summary or explanation; and

B. The patient agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

ATL Colorectal Surgery, P.C. must provide the access as requested by the patient in a timely manner, including arranging with the patient for a convenient time and place to inspect or receive a copy of the PHI, or mailing the copy of the PHI at the patient's request.

ATL Colorectal Surgery, P.C. may discuss the scope, format, and other aspects of the request for access with the patient as necessary to facilitate the timely provision of access.

If the patient requests a copy of the PHI or agrees to a summary or explanation of such information, ATL Colorectal Surgery, P.C. may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:

Copying, including the cost of supplies for and labor of copying, the PHI requested. The fee schedule for these services is ten dollars.

Postage, if the patient has requested the copy, summary, or the explanation is mailed. The fee schedule for postage can be obtained from ATL Colorectal Surgery, P.C.; and

Preparing an explanation or summary of the PHI, if agreed to by the patient.

DENIAL OF PHI PROCEDURE

1. ATL Colorectal Surgery, P.C. must allow a patient to request access to inspect or receive a copy of their protected health information (PHI) maintained in their designated record set. However, ATL Colorectal Surgery, P.C. may deny a patient's request without providing an opportunity for review when:

a) an exception detailed above in the policy statement exists;
b) ATL Colorectal Surgery, P.C. is acting under the direction of a correctional institution and the prisoner's request to obtain a copy of PHI would jeopardize the patient, other prisoners, or the safety of any officer, employee, or other person at the correctional institution, or a person responsible for transporting the prisoner;
c) the patient agreed to temporary denial of access when consenting to participate in research that includes treatment, and the research is not yet complete;
d) the records are subject to the Privacy Act of 1974 and the denial of access meets the requirements of that law; the PHI was obtained from someone other than ATL Colorectal Surgery, P.C. under a promise of confidentiality and access would likely reveal the source of the information.

2. ATL Colorectal Surgery, P.C. may also deny a patient access for other reasons, provided that the patient is given a right to have such denials reviewed under the following circumstances:

a) ATL Colorectal Surgery, P.C. or a licensed health care provider designated or appointed by ATL Colorectal Surgery, P.C. has determined that the access is likely to endanger the life or physical safety of the patient or another person;

b) the PHI makes reference to another person who is not a health care provider, ATL Colorectal Surgery, P.C. or a licensed health care professional designated or appointed by ATL Colorectal Surgery, P.C. has determined that the access requested is likely to cause substantial harm to such other person;

c) the request for access is made by the patient's surrogate decision maker and ATL Colorectal Surgery, P.C. or a licensed health care professional designated or appointed by the ATL Colorectal Surgery, P.C., has determined that access is likely to cause substantial harm to the patient or another person.

3. If access is denied on a ground permitted above, the patient has the right to have the denial reviewed by ATL Colorectal Surgery, P.C. or a licensed health care professional designated or appointed by ATL Colorectal Surgery, P.C. to act as a reviewing official, and who did not participate in the original decision to deny. ATL Colorectal Surgery, P.C. must provide or deny access in accordance with the determination of the reviewing official.

4. If ATL Colorectal Surgery, P.C. denies access, in whole or in part, to PHI, ATL Colorectal Surgery, P.C. must comply with the following requirements:

a) ATL Colorectal Surgery, P.C. must, to the extent possible, give the patient access to any other PHI requested, after excluding the PHI to which ATL Colorectal Surgery, P.C. denied access.
b) ATL Colorectal Surgery, P.C. must provide a timely, written denial to the patient, in plain language and containing:

    1) The basis for the denial;
    2) If applicable, a statement of the patient's review rights, including a description of how the patient may exercise such review rights; and
    3) a description of how the patient may complain to ATL Colorectal Surgery, P.C. pursuant to the ATL Colorectal Surgery, P.C.'s complaint policy.

If the patient has requested a review of a denial, ATL Colorectal Surgery, P.C. must designate or appoint a licensed health care professional, who was not directly involved in the decision to deny access. ATL Colorectal Surgery, P.C. must promptly refer a request for review to such licensed health care professional. The licensed health care professional must determine, within a reasonable period of time, whether or not to deny the access requested based on the aforementioned procedures and standards. ATL Colorectal Surgery, P.C. must promptly provide written notice to the patient of the findings of the reviewing licensed health care professional, and take other action as required by this section to carry out the licensed health care professional's determination.

Enforcement

ATL Colorectal Surgery, P.C.'s office manager and supervisors are responsible for enforcing this policy. Individuals who violate this policy will be subject to the appropriate and applicable disciplinary process, up to and including termination or dismissal.

References: 45 C.F.R. § 164.524