DIGESTIVE HEALTH ASSOCIATES
PROFESSIONAL CORPORATION

Patrick D. Gerstenberger, MD Steven R. Christensen, MD Stuart B. Saslow, MD Laura Parker, NP Kory Williams, PA-C Beth Glotfelty, PA-C

Dear Digestive Health Patient,

We are pleased to offer an online version of our forms to expedite the admissions process for your upcoming upper gastrointestinal endoscopy (EGD) at the Southwest Endoscopy Center. Prior to your procedure you must complete a telephone health history interview with one of our nurses and confirm the scheduling of your procedure with our staff. These steps, and your completion of these forms at home, can eliminate the inconvenience and the added cost of a separate pre-procedure office visit.

Please review and complete the following before your arrival, signing where indicated. Call us in advance if any questions arise.

1. Demographics information form
2. Admission forms
3. Billing information
4. Financial policy
5. Anesthesia advanced beneficiary notice (ABN) for private insurance.

This sample ABN form is furnished for your review only. Animas Anesthesia will "issue" a similar ABN form and request your signature if it reasonably believes that anesthesia services may not be covered in your case.

6. Privacy notice and privacy notice consent form
7. Procedure consent form
8. Instructions for preparation for your examination

Please read your procedure preparation instructions <u>now</u>. Some simple dietary modification in the days before your procedure is needed.

Please have your insurance card and a picture I.D. available when you are checking in at our office.

Feel free to call our office at 970.385.4022 before your scheduled appointment if you have any questions. Let us know immediately if there have been any changes in your health status since you spoke with our nurse. Remember, there are only a few minutes to talk with the doctor before your procedure. If there are issues you wish to discuss you should call us to schedule a separate office appointment.

It is our goal to make your experience with Digestive Health Associates and the Southwest Endoscopy Center as comfortable, confidential, safe and affordable as possible. We look forward to seeing you for your procedure.

Directions to our office (see "Directions" link on our web site homepage for a Google map)

Coming from the east on Highway 160: Turn left at the Double Tree Hotel. Travel west on Highway 160 about ¾ miles. Turn right into the **Durango Tech Center** onto **Durango Tech Center Drive**. Take the first right onto **Burnett Drive**, and turn left onto **Burnett Court.** Our entrance is on your right.

Coming from the west on Highway 160: Travel ½ mile past the Best Western Durango Inn and Suites. Turn left into the **Durango Tech Center** onto **Durango Tech Center Drive**. Take the first right onto **Burnett Drive** and turn left onto **Burnett Court**. Our entrance is on your right.

ASGE Quality
ENDOSCOPY UNIT RECOGNITION PROGRAM

Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

Digestive Health Associates | Southwest Endoscopy Center | Animas Anesthesia Associates
DEMOGRAPHICS INFORMATION FORM

Please Complete and Bring With You

Full Legal Name _____ Age_____

Birth date_____ □ Single □ Married □ Separated □ Divorced □ Widowed
If patient is a Minor:
Name of Person Legally Responsible _____

Mailing Address _____ City _____ Zip _____

Home Address if Different than Mailing _____ City_____ Zip_____

Social Security Number _____ Home Phone _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Name of Spouse _____ Age _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Person to Notify in Case of Emergency (who does not live with you) _____

Relationship to You _____ Phone_____

Family/Referring Physician _____

INSURANCE INFORMATION
Primary Insurance/Medicare: Subscriber #_____ Group #_____

Insurance Co. : _____ Subscriber Name _____DOB_____

Effective Date: _____

Secondary Insurance: Subscriber # _____ Group #_____

Insurance Co: _____ Subscriber Name _____DOB_____

Effective Date _____

Please be prepared to present your insurance card to the receptionist for copying.

STATEMENT OF RESPONSIBILITY, ASSIGNMENT OF MEDICAL BENEFITS AND AUTHORIZATION FOR RELEASE OF INFORMATION

Payment is expected on the day of service.

I agree that if I or my minor children are covered by insurance, and if my carrier does not pay in full for services any one of us receive through Digestive Health Associates, PC (DHA), Southwest Endoscopy Center, RLLLP (SEC) or Animas Anesthesia Associates, LLC (AAA), that I am personally responsible for payment of this balance within 15 days of billing.

I understand that if any unpaid portion of my personal balance becomes delinquent that it may begin to accrue interest.

In the event my personal balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorney's fees incurred by DHA, SEC and AAA in said collection efforts.

My signature below represents my understanding and acceptance of this policy. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release by DHA, SEC and AAA any medical information necessary to process any claim or appeal on my behalf.

Patient _____
Date _____

Southwest Endoscopy Center (Center)

AUTHORIZATION AND CONSENT FOR ENDOSCOPIC PROCEDURES & CONDITIONS OF ADMISSION

CONSENT TO ADMISSION AND PROCEDURE: Your physician has recommended that you undergo Endoscopy (Colonoscopy or EGD). This procedure, together with any different or further procedures which in the opinion of your physician may be indicated due to any emergency, will be performed on you by your physician, together with associates and assistants to whom the supervising physician may assign designated responsibilities. If he has not already done so, your physician will obtain your informed consent to treatment for the procedure you will undergo.

INDEPENDENT CONTRACTORS: The persons who perform specialized medical services such as pathology are not agents or employees of the Center or your supervising physician. They are independent contractors and the Center is not responsible or liable for their acts or omissions.

TISSUE DISPOSAL: I authorize the pathologist to use his discretion in disposing of any tissue removed from your person during the operation or procedure set forth above.

RELEASE OF INFORMATION TO CORI: I authorize release of information from today's procedure via the internet to the Clinical Outcomes Research Initiative (CORI), a national computer database researching outcomes from gastroenterology (GI) procedures. Access to the CORI database is limited to clinical researchers evaluating outcomes from GI procedures and deriving standards of practice within the subspecialty of gastroenterology as a whole. The information released to CORI contains only general information about your procedure; no personal, identifying information (such as name, address, or social security number) is sent to CORI.

LEGAL RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN: I acknowledge that I have been informed that Southwest Endoscopy Center is owned by a Limited Liability Limited Partnership, which in turn is owned in part by Dr. Patrick D. Gerstenberger, Dr. Steven R. Christensen, and Dr. Stuart B. Saslow. The Center therefore has a financial relationship with the physician treating you.

RELEASE OF INFORMATION: I agree that the Center may disclose information on me, including my medical records, to any third-party payors, including, but not limited to, health insurers, health care service plans, welfare agencies, worker's compensation carriers, or my employer. My record may also be disclosed to my physicians as necessary for my health care.

FINANCIAL AGREEMENT: I agree to pay the Center in accordance with its regular rates and terms. Should my account be referred to an attorney for collection, I shall pay the Center's reasonable attorney's fees and collection expenses. I shall also pay interest at the legal rate on my unpaid balance. If you do not have insurance coverage, it is our policy to collect payment *in full* prior to or at the time of service. SEC can offer a 20% discount on your bill if you do not have insurance, only if you pay in full at the time of service. If you do have insurance coverage, we will prepare a claim and send it to your insurance company for you. In the event that your insurance plan determines a service to be "not covered," you will be responsible for the charges. A schedule of typical fees for services provided in the Center is available for review upon request.

INFORMED BILLING PRACTICES: I understand that I will receive separate bills from Southwest Endoscopy Center for the FACILITY FEE and from Digestive Health Associates for my PHYSICIAN'S CHARGES. I may also receive bills for PATHOLOGY and/or for LABORATORY services.

HEALTHCARE SERVICE PLAN OBLIGATION: This Center maintains a list of health care service plans with which it has contracted. A list of these plans is available upon request. The Center has no express or implied agreement with any plan that does not appear on the list. I agree that I am obligated to pay all charges by the Center if I belong to a plan which is not under contract with it.

ASSIGNMENT OF BENEFITS: I authorize direct payment to the Center of any insurance benefit. I understand that I am financially responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII 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 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.

TRANSFER: I authorize the Center to transfer you to another health care facility should your physician determine it to be necessary.

ADVANCE DIRECTIVE GUIDELINES: I acknowledge the Southwest Endoscopy Center's policy that life-sustaining efforts will be initiated and maintained on all patients who may have a cardiac/respiratory event during or following a procedure within this facility. If available, copies of any advance directives will accompany patient being transferred to another facility.

PATIENT REPONSIBILITIES: I have informed Southwest Endoscopy Center if I have a living will, medical power of attorney, or advance directives. I understand that in order to receive the best possible care, I must provide complete and accurate information about my health and any and all medications I am taking, and to follow the treatment plan prescribed by my provider, while under his or her care. I agree to be respectful of all healthcare providers and staff as well as other patients. I am responsible for safe transport to and from the facility.

I certify that I have read this document, received a copy of it, and am the patient, or am duly authorized to execute it and accept its terms.

_____

Print Patient Name Patient/Parent/Guardian Signature Date

_____

If Other Than Patient, Indicate Relationship

CONSENT TO BE CONTACTED BY CORI NATIONAL ENDOSCOPIC DATABASE

CORI NATIONAL ENDOSCOPIC DATABASE, Oregon Health Sciences University 3181 SW Sam Jackson Park Road Portland Oregon 97201

The Digestive Health Center is a participating research site for the Clinical Outcomes Research Initiative (www.cori.org) and the National Endoscopic Database. We ask that you consider providing consent for the National Endoscopic Database to contact you in the future, if your findings today make you eligible to participate in one of our research studies. This research is voluntary on your part. We receive no compensation for our participation in these studies, which is motivated by our commitment to furthering the understanding of and improving the diagnosis and treatment of intestinal diseases.

I consent to have an investigator affiliated with the National Endoscopic Database call me to discuss my participation in future research studies related to the examination I will undergo today. I know that I will be called only if I qualify for a research study. I understand that I may refuse to participate in any of these research projects when they are explained to me. I also understand that I can change my mind in the future and take back (rescind) this consent to being contacted by an investigator. If I decline to have an investigator call me, this will not affect my medical care at this clinic in any way. The research is funded by the National Institutes of Health.

_____

Patient Signature

Digestive Health Associates and Southwest Endoscopy Center
PATIENT BILL OF RIGHTS

The Southwest Endoscopy Center adopts and affirms as policy the following rights of patient/clients who receive services from our facility.

This policy affords you, the patient/client, the right to:

1. Treatment without discrimination as to race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual in a manner that recognizes their basic human rights.
2. Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
3. Receive, upon request, the names, professional status, and experience of all personnel participating in your care.
4. Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
5. Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other appropriate treatment methods, if any.
6. The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The Facility will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
7. Upon request, the facility will assist you in formulating advance directives and appointing a surrogate to make health care decisions on your behalf, to the extent permitted by law. Access to health care at this facility will not be conditioned upon the existence of an advance directive.
8. Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
9. Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment contract.
10. A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
11. Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
12. Refuse to participate in research. Human experimentation affecting care or treatment shall be performed only with your informed consent.
13. Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
14. Know the facility's rules and regulations that apply to your conduct as a patient.
15. The privacy and confidentiality of others must be respected.
16. Any unanswered concerns on the part of patients or family relative to ethical issues can, with sufficient notice, be referred to our Continuous Quality Improvement Committee for advice. It is your responsibility to immediately report any safety concerns to your physician or the management.
17. Complaint or criticisms will not compromise future access to care at this facility. Staff will gladly advise you of the procedure for registering a complaint/grievance.

Patient Responsibilities

As our patient, you agree to:

1. Provide complete and accurate information to the best of your ability about your health, medications, and any allergies or sensitivities.
2. Follow the treatment plan prescribed by your provider and participate in your own care.
3. Be responsible for your own safe transport to and from our facility.
4. Accept personal financial responsibility for any charges not covered by your insurance (subject to contractual limitations).
5. Be respectful of all healthcare providers and staff, as well as other patients.

Complaints may also be addressed to:

State of Colorado	**State of Colorado**	**Medicare Program**
Health Facilities Division Division Director Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, Colorado 80222-1530 Main switchboard: (303) 692-2800 http://www.colorado.gov/cs/Satellite/CDPHE-HF/CBON/1251583470236	Colorado Division of Registrations Board of Medical Examiners Complaints 1560 Broadway, Suite 1350 Denver, CO 80202 Phone: 303-894-7598 http://www.dora.state.co.us	1-800-MEDICARE http://www.medicare.gov/Ombudsman/resources.asp

BILLING INFORMATION

YOU WILL RECEIVE MULTIPLE BILLINGS FOR SERVICES RENDERED IN OR THROUGH OUR FACILITY:

To assist you in expediting efficient processing of your claims we ask that you provide the receptionist with accurate, current insurance information. This information will be forwarded to any of the organizations listed below that may have been associated with your care at this facility.

If you should require assistance, or have any questions regarding your billing, please use the table below to determine who may be able to best answer your questions.

BILL TYPE	COVERS	YOUR CONTACT
Facility Fee	**Facility Usage** **Equipment Usage** **Nursing & Supplies**	**Southwest Endoscopy Center, RLLLP** **Phone: 970.828.2052** **Hours: 8:00 - 5:00** **Mon-Fri**
Pathology Fee	**Pathologist** **Professional Services**	**AmeriPath** **Phone: 877.701.8188** **Hours: 8:00 - 5:00**
Laboratory Fee	**Laboratory Services** **Services** **Processing of Specimens**	**Mercy Regional Medical Center** **Phone: 970.764.1100** **Hours: 8:00 - 5:00**
Physicians Fee	**Procedure**	**Digestive Health Associates, PC** **Phone: 970.828.2058** **Hours: 8:00 - 5:00** **Mon – Fri**
Anesthesia Fee	**Anesthesia Services**	**Animas Anesthesia Associates, LLC** **Phone: 888.819.7818 (toll-free)** **Hours: 6:30 – 5:30**

PLEASE KEEP THIS FORM FOR REFERENCE

FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and these practices, we have adopted this financial policy. If you have any questions, please do not hesitate to discuss them with our facility administrator. We are dedicated to providing the best possible care and service to you, and we regard the understanding of your financial responsibilities as an essential element of your care and treatment.

PRIMARY INSURANCE

We currently have direct arrangements with several insurance companies, including Anthem Blue Cross and Blue Shield, HMO Colorado, Rocky Mountain Health Plans, BlueCross BlueShield of New Mexico, Presbyterian Healthcare Services, Lovelace Health Plan, Sloans Lake/Cofinity, Durango Network, UnitedHealthcare, Pacificare, CIGNA, Medicare and Colorado Medicaid, to accept their allowed amount. We will bill these plans directly, and will require you to pay only the authorized co-payment and deductible. **It is the policy of this office to collect the co-payment at the time of service.**

We anticipate periodic additions and deletions to our list of contracted plans. Please contact our office or check our web site (www.digestivehealth.net) for current information regarding our participation status.

If you have insurance coverage through a plan with which we do not currently participate, we will collect from you any amounts not paid by your insurance. We will prepare and send your insurance company a claim. The insurance company may send the payment to you or to us. If it is sent to you, full payment on your account balance must be made immediately on receipt of the insurance check. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge.

If your insurance requires a referral from a primary care provider, it is your responsibility to obtain one.

SECONDARY INSURANCE

Our office will submit secondary insurance claims for you.

DISCOUNTS

If you do not have insurance coverage, we can offer you a discount on your bill if you pay in full at the time of service.

SELF PAY

If you do not have insurance coverage, it is our policy to collect payment in full at the time of service. Any payment arrangements must be approved by the billing department. We may charge interest on past due accounts.

LATE CANCELLATION FEES

Digestive Health Associates charges a fee for visits or procedures that are not cancelled within 24 hours of the scheduled appointment. The fees are: $25 for an office visit, and $100 for a procedure (at either Southwest Endoscopy Center or Mercy Regional Medical Center).

LATE PAYMENT FEES

Digestive Health Associates and Southwest Endoscopy Center charge a $25 per month late payment fee for balances that have been due from the patient for over 90 days.

PAYMENT OPTIONS

Digestive Health Associates and Southwest Endoscopy Center accept: Cash, Check, Visa, MasterCard, and DiscoverCard.

I agree that if I am covered by insurance and if my carrier does not pay in full for services I receive through Digestive Health Associates PC ("DHA"), Southwest Endoscopy Center, RLLLP (SEC) and/or Animas Anesthesia Associates, LLC (AAA), that I am personally responsible for payment of this balance within 15 days of billing. I understand that if any unpaid portion of my personal balance becomes delinquent that it may begin to accrue interest. In the event my personal balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorney's fees incurred by DHA,SEC and/or AAA in said collection efforts. My signature below represents my understanding and acceptance of this policy. I hereby assign all medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release by DHA, SEC and/or AAA of any medical information necessary to process any claim or appeal on my behalf. I have read and understand the financial policy of the practices and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practices.

_____ _____

Signature of Patient/Responsible Party *Date*

Printed Name of Patient

Animas Anesthesia Associates, LLC, PO Box 4860, Murrells Inlet, SC 29576
888.819.7818 (toll-free)

(A) ***Notifier: Animas Anesthesia Associates, LLC***
(B) ***Patient Name:*** **(C)** ***Identification Number:***

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: *If your insurance company doesn't pay for* **(D) Anesthesia** *below, you may have to pay.*

Your insurance company may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay for the **(D) Anesthesia** *below.*

(D) Anesthesia	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**
Anesthesia for endoscopic procedure	Your insurance company may not consider this service to be medically necessary	$150

WHAT YOU NEED TO DO NOW:

- *Read this notice, so you can make an informed decision about your care.*
- *Ask us any questions that you may have after you finish reading.*
- *Choose an option below about whether to receive the* **(D) Anesthesia** *listed above.*
  Note: *If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.*

***(G)* OPTIONS:**	**Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D) Anesthesia*** listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of benefits (EOB). I understand that if my insurance company doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB**.** If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D) Anesthesia*** listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance company is not billed**.

❑ **OPTION 3.** I don't want the ***(D) Anesthesia*** listed above. I understand with this choice I am **not** responsible for payment, and I **cannot appeal to see if my insurance company would pay**.

(H) ***Additional Information:***

This notice gives our opinion, not an official insurance company decision. If you have other questions about this notice please contact your insurance company at the number listed on your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

NOTICE OF PRIVACY PRACTICES

Effective Date: June 1, 2013

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 about this notice, please contact Marianne Sloan, Facility Administrator.

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice and that of:
• Any health care professional authorized to enter information into your office chart;
• All departments and units of this office practice;
• Any member of a volunteer group we allow to help you while you are in the office;
• Any medical student, intern, resident or fellow that we allow to help you while you are in the office;
• Any representative of an insurance carrier, managed care organization, clinical research organization, data analysis organization, or quality improvement organization that is participating in a review of your medical care;
• All employees, staff and other office personnel; and,
• All other entities, sites and locations where the health care professionals in this office practice and follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or operations purposes as described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office, whether made by office personnel or your personal doctor. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
-make sure that medical information that identifies you is kept private;
-give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.
-notify you in the event of a breach of confidentiality that affects you.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment - We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other office personnel who are involved in taking care of you at the office. For example, a doctor treating you for an intestinal condition may need to know if you have diabetes because diabetes may affect the management of your intestinal problem. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for you to receive information regarding appropriate meals. Different departments of the office also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, endoscopy examinations and x-rays. We also may disclose medical information about you to people outside the office who may be involved in your medical care after you leave the office, such as your primary care physician/provider, other medical consultants, family members, clergy or others we use to provide services that are part of your care.

Payment - We may use and disclose medical information about you so that the treatment and services you receive at the office, hospital, endoscopy center, nursing home or other site may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about the services you received at the office, hospital or endoscopy center, so that your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Health Care Operations - We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to operate the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. We may also combine the medical information we have with medical information from other offices to compare how we are doing and see where we can make improvements in the care and services that we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders - We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office or endoscopy center.

Treatment Alternatives - We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services - We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Endoscopy Center Directory - We may include certain limited information about you in the endoscopy center directory while you are a patient at the Southwest Endoscopy Center. This information may include your name, location in the endoscopy center, and your general condition (e.g., fair, stable, etc.) This is so your family and friends can visit you in the endoscopy center and generally know how you are doing.

Individuals Involved in Your Care or Payment for Your Care - We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital, endoscopy center or office. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research - Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the office. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

As Required By Law - We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety - We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation - If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans - If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

Workers' Compensation - We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and,
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities - We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement - We may release medical information if asked to do so by a law-enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office or ambulatory surgery center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors - We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities - We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others - We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Department of State - We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes.

Inmates - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy - You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the facility administrator. If you request a copy of the information, we may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend - If you feel that medical information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office. To request an amendment, your request must be made in writing and submitted to the facility administrator. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the office;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

Right to an Accounting of Disclosures - You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the facility administrator. Your request must state a time-period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before incurred.

Right to Request Restrictions - You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. *We are not required to agree to your request*. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the facility administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the facility administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, http://www.digestivehealth.net. To obtain a paper copy of this notice, contact the facility administrator.
Right to Opt Out of Receiving Fundraising Communications – A covered entity that intends to contact an individual to raise funds must inform the individual of its intention and the individual's right to opt out of receiving such communications.
Right to Restrict PHI disclosures to health plans when the patient has paid out of pocket and in full. If you pay for your healthcare out of pocket and in full, we may not disclose PHI about you to any health plan with your express consent.
We may not sell your PHI without your express written consent

CHANGES TO THIS NOTICE We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are seen at the office for treatment or health care services as an outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Marianne Sloan, facility administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PARTICIPATION WITH COLORADO REGIONAL HEALTH INTEGRATION ORGANIZATION (CORHIO HIE):
Digestive Health Associates and the Southwest Endoscopy Center endorse, support, and participate in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize Digestive Health Associates and the Southwest Endoscopy Center to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Digestive Health Associates and the Southwest Endoscopy Center can refuse to treat me. I have been informed that Digestive Health Associates and the Southwest Endoscopy Center has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Digestive Health Associates and the Southwest Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Digestive Health Associates and the Southwest Endoscopy Center took before receiving my revocation.

I understand that Digestive Health Associates and the Southwest Endoscopy Center have reserved the right to change their privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that Digestive Health Associates and the Southwest Endoscopy Center restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Digestive Health Associates and the Southwest Endoscopy Center do not have to agree to such restrictions, but that once such restrictions are agreed to, Digestive Health Associates and the Southwest Endoscopy Center must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative *Date*
(Form MUST be completed before signing)

_____
Printed name of patient or patient's representative

_____
Relationship to the patient

CONSENT FOR UPPER GASTROINTESTINAL ENDOSCOPY

This document helps us inform you about this procedure. Please read it carefully and address any questions or concerns you may have personally with the doctor prior to signing it.

Dr. Patrick D. Gerstenberger, Dr. Steven R. Christensen, Dr. Stuart B. Saslow or Dr. Emily K. Ward and his or her assistants, and a certified nurse anesthetist (CRNA), are authorized to perform:

Upper Gastrointestinal Endoscopy - Examination of the esophagus, stomach and duodenum with a flexible tube passed through the mouth.
Biopsy - Remove small pieces of tissue for analysis
Polypectomy - Remove small growths
Dilation - Enlarge a narrowed area
Cautery/injection/sclerotherapy/band ligation/clip application - Use specialized instruments to apply heat, medication, small rubber bands or metal clips applied internally to stop or prevent bleeding
Removal of foreign body
Placement of tubes or stents
Procedural sedation/anesthesia (with monitored anesthesia care) – Administration of medication into a vein, by a certified registered nurse anesthetist (CRNA) under your doctor's supervision, prior to and during the procedure, to make the procedure comfortable by relieving anxiety, discomfort, and pain. Most patients experience partial or total amnesia for their procedure with this form of sedation/anesthesia.

Upper gastrointestinal endoscopy is frequently performed for: evaluation of symptoms (such as heartburn, swallowing problems, abdominal pain, bleeding, diarrhea and weight loss), screening for, follow-up and treatment of Barrett's esophagus, treatment of a narrowing (stricture), follow-up of gastric ulcer, evaluation of anemia, placement of tubes or stents and removal of foreign bodies.

ALTERNATIVES: Imaging tests ("upper GI series," CT scan, MRI, ultrasound, nuclear scans) are sometimes recommended as alternatives. Imaging tests are less likely to cause a complication, but are less accurate for diagnosis of some conditions, and do not allow treatment, such as dilation of a narrowing. No test at all is an alternative, but no testing carries risks of failing to diagnose a problem at an early and more treatable stage. In most cases we perform upper endoscopy using procedural sedation/anesthesia, which is provided by a CRNA under the endoscopy doctor's supervision. It may be possible to perform this procedure without sedation, or with moderate sedation, during which the patient remains conscious throughout the procedure. Anesthesia care provided by an anesthesiologist may be used in some cases. This alternative is available at Mercy Regional Medical Center.

RISKS: These procedures involve some risks. Major complications include: **perforation** (<1/3000), **bleeding** requiring blood transfusion or surgery (<1/3000), **heart or lung problems** (major problems are rare), infection (rare), allergic reactions (rare), nerve injury (rare) and death (rare). Minor complications (needle site irritation, dental injury, internal burns or bruises, minor medication reactions, temporary bowel distention or prolonged sleepiness) occur infrequently. Complications occur more frequently when polyps are removed, bleeding is treated, or foreign bodies are removed. These are highly accurate procedures, but with any medical test there is a small chance of missing something.

Complications may occur even when a procedure is properly performed. Treatment of major complications may require hospitalization, surgery, and blood transfusion.

SEDATION/ANESTHESIA: Sedation/anesthesia involves a risk of heart, lung, allergic or other drug reaction problems (<1/200), which rarely (<1/160,000) can be fatal. Sedation/anesthesia is administered and monitored by a CRNA under the supervision of the physician performing your procedure. Anesthesiologist (a specialist physician providing sedation/anesthesia) services are not available at the Southwest Endoscopy Center but are available at Mercy Regional Medical Center and can be arranged at the request of either the patient or the physician performing your procedure.

MEDICATIONS THAT AFFECT BLOOD CLOTTING: Your doctor may recommend that these drugs (such as Coumadin, Pradaxa, Xarelto, Eliquis, Plavix, Effient, aspirin, nonsteroidal anti-inflammatory agents and others) be discontinued before colonoscopy to reduce possible bleeding risk related to polyp removal. Stopping and restarting these drugs however carries some risk of blood clot related problems, including stroke and heart attack. In some cases we may advise you to undergo colonoscopy without stopping these medications, in the belief that possible bleeding is less of a risk to your health than the risk of possible heart attack or stroke.

RECUPERATION: Recuperation from endoscopy is generally complete within a few hours following the procedure. Most individuals can return to typical activities and diet at that time. Because the effects of sedation on memory, coordination and judgment may linger however, activities such as driving, operation of machinery, vigorous physical exertion or activities requiring full mental attention, coordination or recall should not be resumed until the following day. **Increasing throat, chest or abdominal pain, bleeding, fever, chills or other signs of illness could be signs of complication of endoscopy or of your sedation, and should be reported promptly to the on call Digestive Health physician.** You will be provided with written instructions on discharge telling you how to contact us in the event of a problem after the procedure.

TRANSFUSION: Blood transfusions are not administered at the Southwest Endoscopy Center. Transfusions are occasionally administered at Mercy Medical Center during endoscopy if a patient has lost a large amount of blood prior to the procedure. A separate written consent prior to transfusion is obtained if transfusion is needed.

SUCCESS: Complete examination of the upper gastrointestinal tract is nearly always achieved. Most areas of narrowing (strictures) we detect are dilated at the time of the examination. Some strictures may require additional endoscopy procedures or surgery to allow complete dilation. Most swallowed foreign bodies can be removed successfully, though surgery may occasionally be necessary.

ASSISTANTS: Registered nurses and/or technicians who are employees of the facility providing your procedure will assist the physician. Students, industry representatives or other observers will not be permitted to be present without your written permission. CRNA services at this facility are provided by Animas Anesthesia Associates, LLC, a wholly-owned subsidiary of Digestive Health Associates, P.C. Other physicians or assistants are rarely necessary during endoscopy, though occasionally the physician may request an opinion regarding a finding or technique from another physician during a procedure.

PATIENT CONSENT
I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed procedure.

I have read and fully understand this form and I voluntarily authorize and consent to this procedure. I understand that I should not sign this form until all my questions have been answered to my satisfaction and until I understand all the words or terms on this form.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I have been advised that the proposed procedure may not improve my condition and may, in fact, worsen it.

*X*_____ *Date:* _____ *Time:* _____
Signature of Patient or Authorized Agent

_____
Printed Patient Name

PHYSICIAN/PROVIDER DECLARATION
I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____ *Date:* _____ *Time:* _____
Physician Assistant or Nurse Practitioner (if applicable)

_____ *Date:* _____ *Time:* _____
Physician performing procedure

_____ *Date:* _____ *Time:* _____
CRNA (declaration limited to matters pertinent to anesthesia consent)

GENERAL PREPARATION FOR ENDOSCOPIC PROCEDURES

MEDICATIONS:

A. DO NOT STOP HEART AND BLOOD PRESSURE MEDICATION. Take your last dose at least 4 hours before your scheduled procedure with a few sips of water.

DO NOT STOP ASPIRIN, CLOPIDOGREL (PLAVIX®), PRASUGREL (EFFIENT®), COUMADIN® (WARFARIN), PRADAXA® (DABIGATRAN), XARELTO® (RIVAROXABAN), ELIQUIS® (APIXABAN) WITHOUT SPECIFIC DIRECTION FROM OUR OFFICE TO DO SO. PLEASE INFORM US IF YOU TAKE THESE MEDICATIONS, AND THE REASON YOU DO.

You may take acetaminophen (Tylenol®) for minor aches and pains if needed.

B. YOU SHOULD AVOID THE FOLLOWING MEDICATIONS PRIOR TO YOUR PROCEDURE, as they may increase the risk of bleeding or cause other procedural difficulties.

7 days before your procedure, stop:

- **Ginko biloba**
- **St. John's Wort**
- **Olestra (Olean®) -** an artificial fat used in some snack foods such as potato chips, tortilla chips, cheese puffs, popcorn and crackers (Pringles® Light Original, and Pringles Light Sour Cream & Onion crisps, LAY'S Light Original Potato Chips, RUFFLES Light Cheddar and Sour Cream Flavored Potato Chips, RUFFLES Light Original Potato Chips and TOSTITOS Light Restaurant Style Tortilla Chips).

2 days before your procedure, stop:

- Nonprescription: **Ibuprofen (Motrin®, Advil®, Nuprin®, Medipren®), Naproxen (Aleve®,), Ketoprofen (Orudis®)**
- Prescription Anti-inflammatory medications (examples include: **Anaprox®, Ansaid®, Arthrotec®, butazolidin, Cataflam®, Clinoril®, Daypro®, Dolobid®, Feldene®, Indocin®, meloxicam, Motrin®, Naprelan®, Naprosyn®, naproxen, Oruvail®, Ponstel®, Relafen®, Toradol®, Trilisate®, Voltarin-XR®**).

CLEAR LIQUID DIET:

To qualify as a clear liquid, you must be able to see through the liquid (it may be colored, though avoid red or purple fluids). A clear liquid diet helps to clear the digestive tract of as much food residue as possible prior to your procedure.

Allowed foods:

Clear fruit juices, e.g. apple, white grape
Gelatin (lemon, lime or orange; no fruit toppings)
Popsicles (no sherbets or fruit bars)
Fruit ices of the above fruit juices
Black coffee (no milk or non-dairy creamers added)
Black tea (no milk or non dairy creamers added)
Carbonated beverages, e.g. Sprite®, Fresca®, ginger ale, cola
Kool-aid®
Soup: low-sodium chicken or beef bouillon / broth.
Honey, sugar, hard candies
Gatorade® and similar sports drinks
WATER!

Avoid large amounts of fluid colored red or purple.

PREAUTHORIZATION:

Please contact your insurance carrier in advance to verify your benefit and coverage levels. Digestive Health Associates will call to preauthorize your procedure, but you should call to verify your benefit and coverage levels. If you don't follow your policy's rules, it might not cover the expenses of your test with maximum benefit. Preauthorization is never a guarantee of coverage or payment.

Please do not hesitate to call us with any questions! 970-385-4022

PREPARATION FOR UPPER GI ENDOSCOPY (EGD)

You will be given a sedative for this procedure, and will not be able to drive until the following day. **Arrange in advance for someone to drive you home.**

Diet:

Morning procedures: Do not eat or drink anything except for clear liquids after midnight the night before your procedure. All oral intake, including clear liquids, must be stopped 2 hours before your procedure. You should take your regular medications, as instructed, with a sip of water, at least 2 hours before arrival.

Afternoon procedures:

a. Do not eat any solid food after midnight.
b. You should take your regular medications, as instructed, with a sip of water.
c. You may have clear liquids until 2 hours before your scheduled procedure. A liquid is "clear" if you can see through it (water, juices, clear soup, Jell-O that is not colored red, soft drinks, black coffee/tea).

Please call us if you have any questions.
970-385-4022

Final friendly reminders…

Our goal is to provide you with a safe, complete and accurate examination. For us to do this you must:

1. Arrange in advance for a ride home by a responsible adult after sedation/anesthesia.
2. Limit your diet as instructed.
3. **Do not eat or drink <u>absolutely anything</u>** for **2 hours** prior to your procedure.
4. **Do not chew gum or tobacco** for **2 hours** prior to your procedure.
5. Do not use alcohol, marijuana or medications that may cause acute intoxication or impairment prior to your procedure.

Please call us if you have any questions about how you should prepare for your procedure.