



ADA Policy Acknowledgement and Accommodation Request

GCSA is committed to compliance with federal and state laws prohibiting discrimination on the basis of disability in the offering or delivery of healthcare services. GCSA recognizes its legal obligation to ensure effective communication with persons with disabilities and makes every effort to proactively assess communication needs as well as providing the most compassionate care.






GCSA staff will take appropriate steps to ensure persons with disabilities, including persons who may be deaf or hard-of-hearing, have an equal opportunity to obtain healthcare services with GCSA. This includes patients and their Companions. Please review our policy and procedures:

www.gastroclinicsa.com

I _____ (patient name) have read the policy and I am requesting for myself or for my companion:

____ (Patient Initial) **Accept-** I wish to receive No cost Services for myself or for my companion who are Deaf or Hard- of -Hearing

____ **Self** ____ **Companion** **Name of Companion** _____

Qualified American Sign Language (ASL) Interpreter • If "No" is selected, please complete the Waiver of Language Assistance Below		YES	NO
TTY with a Light Signaler (if available)		YES	NO
Amplified Telephone Receiver (if available)		YES	NO
Assistive Listening Device (if available)		YES	NO
Closed Caption TV		YES	NO

____ (Patient Initial) **Decline-** I wish to waive my rights to no cost Services for persons who are Deaf or Hard- of -Hearing. I understand at any time I can change my waiver of services and GCSA will provide interpretation services at no charge.

I understand that if I have other accommodation requests, I can request information by contacting info@gastroclinicsa.com

Patient/Guardian Signature _____

Date ____/____/____