WOODHOLME
GASTROENTEROLOGY ASSOCIATES
A LifeBridge Health Partner

Procedure Cost

The cost of your procedure is dependent on your specific health insurance plan and your coverage benefits. It will also depend on your medical situation and the procedure the physician recommends. If you have a high deductible plan, you may experience the maximum out of pocket cost.

Your procedure consists of various medical providers and include the:

- facility, including the nursing staff where your procedure is being done
- physician
- anesthesia provider
- laboratory and pathology

Each of these medical providers will have an associated fee. Since the facility is a separate business unit from the providers, you will receive 2 bills—one for the facility and one for the professional staff.

Occasionally patients make one payment for both balances at the same time via check or credit card. Please be informed that combined payments will need to be allocated to the appropriate business unit. We will transfer the payments as appropriate.

We will give you the deductible and co-pay estimate information when we speak to you to confirm your procedure or you may call our billing department at 410-602-9343. We also recommend you call your insurance company to determine your financial responsibility.

It is best to bring 2 checks if you plan on paying by check. Please sign below indicating your agreement with the transfer of payments between business units.

Patients can also prearrange for a payment plan by calling 410-602-9343.

Thank you.

____ __________________

Signature Date

My signature indicates my agreement with the transfer of payment between business units.

Please see the reverse side for Prep Instructions

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IMPORTANT:

1. STOP Iron tablets 1 week before your procedure.
2. STOP Phenteramine, and <u>other weight reduction medications</u> 2 weeks before your procedure.
3. You must notify the office of all prescriptions you are taking. Patients with diabetes or heart disease may need specific instructions.
4. It is critical that you notify the doctor if you take **Aspirin, Plavix, Coumadin (Warfarin), Effient, or Pradaxa.**

REMEMBER:

1. DO NOT Eat: Raw fruits, nuts, raw vegetables, or fiber supplements 3 days before your procedure.
2. DO NOT Chew gum or have hard candy the day of your procedure.
3. DO NOT Smoke the day of your procedure.

THE DAY BEFORE YOUR COLONOSCOPY:

1. You are to have only **CLEAR Liquids** with no Red dye.

   Clear liquids include: Juices without pulp, water, broth, black coffee, or black tea, and Gatorade. You may have Jell-O, soda, and popsicles so long as they are not colored red.
2. Do not have: solid foods, milk or milk products.
3. Drink 6-8 glasses of water starting 8AM until 5PM to get yourself well hydrated.

<u>PLEASE SEE THE INSTRUCTIONS ON HOW TO TAKE YOUR BOWEL PREP SOLUTION</u>

DAY OF THE PROCEDURE (COLONOSCOPY AND/OR EGD)

1. You may not eat anything including gum and hard candy.
2. You may drink clear fluids only up to 4 hours before your procedure.
3. *<u>You must have someone to drive you home because you will be receiving intravenous sedatives.</u>*
4. If on blood pressure medications please take as directed with a small sip of water.
5. Do not take diabetes pills.
6. Decrease your insulin dose by ½.
7. You may brush your teeth but do not swallow.

If you experience vomiting, please contact the office or the on-call physician.
If you use inhalers, bring them with you to the Endoscopy Centre.
Please call us immediately if you have any questions or concerns.

Endocentre of Baltimore
1838 Greene Tree Rd.
Suite 180
Baltimore, MD 21208
Phone: 410-602-7782

Endocentre at Quarterfield Station
7704 Quarterfield Rd.
Suite I
Glen Burnie, MD 21061
Phone: 410-863-4899

EndoCentre of Baltimore
1838 Greene Tree Road, Suite 180
Baltimore, MD 21208
Phone: 410-602-7782 / Fax: 410-602-9345

EndoCentre at Quarterfield Station
7704 Quarterfield Road, Suite I
Glen Burnie, MD 21061
Phone: 410-863-4899 / Fax: 410-484-9375

Please read, fill out and sign all forms.
DO NOT DATE. Bring completed
forms with you the day of procedure.
Questions will be answered then.

Dear Patient:

You are scheduled for an appointment at the EndoCentre. Please note that nothing by mouth after midnight includes gum, mints and hard candy. You can brush your teeth before your procedure just don't swallow. We ask that you arrive **30 minutes prior** to your scheduled time. We ask that you do not wear jewelry or bring any valuables with you the day of your procedure. We are not responsible for the loss or damage to any valuables, jewelry or belongings.

Unless your physician has told you otherwise, you will be receiving **Anesthesia** for your procedure. **YOU MUST HAVE A RESPONSIBLE ADULT WITH YOU, TO DRIVE AND ESCORT YOU HOME**, following the procedure. Your responsible adult must come into the Suite to sign a paper before you will be released for discharge. Due to allergies and medical conditions of others, we ask that patients and escorts **refrain from wearing perfumes and cologne.**

PRE-ADMISSION TESTING: If you were given pre-admission test orders by your Gastroenterologist, please take them to your Primary Care Doctor and have them fax the test results to us **as soon as possible.**

EndoCentre of Baltimore Fax: 410-602-9345

EndoCentre at Quarterfield Station Fax: 410-484-9375

BOWEL PREPARATION: If your procedure requires **bowel preparation**, you have received those instructions from your physician or his/her secretary. It is very important that you follow the bowel prep instructions as directed. If you experience difficulty with the prep or have any questions, you must contact the physician's office. *If the office is not yet open, please ask answering service to contact the "on call" physician.*

MEDICATIONS:

- **If you take Aspirin, Coumadin (Warfarin), or any other blood thinners: Please speak with your GI Physician about their use prior to the procedure.**
- Take ***blood pressure, heart or seizure medication*** on the morning of your procedure with a **small sip of water**.
- If you have been prescribed an inhaler for Asthma, **PLEASE BRING THE INHALER WITH YOU, EVEN IF YOU RARELY USE IT.**
- If you take **Insulin or Oral Diabetic Medication**, please follow your Primary Care/GI Physician's directions.
- **Diabetic** patients that take **Insulin**, please **test your blood sugar at home on the morning of your procedure**. If your reading is not within your normal range, *please notify your Primary Care/GI Physician. If the office is not yet open, please ask answering service to contact the "on call" physician.*

INSURANCE INFORMATION: We recommend that you contact your insurance company to see if there is anything special that needs to be addressed by our office. Managed Care patients may need a referral from your Primary Care Physician for the procedure. **BRING ALL INSURANCE CARDS AND PICTURE ID WITH YOU.** We will need to copy them at the EndoCentre.

ADVANCE DIRECTIVES: If you have **Advance Directives**, please bring a copy with you. It is our policy, in the event of an emergency situation, to transport you to the nearest hospital. Your copy of Advance Directives, if available, will be sent to the hospital.

Cancellations made with less than 48 hours notice will be subject to a cancellation fee.

We look forward to seeing you. If you have any questions, please contact your Gastroenterologist's office. Thank You.

Sincerely,

The EndoCentre Staff

Medication List

Name ______________________________ Date of Birth ______________________

Today's Date ____________ Reason for Visit ______________________________

Please complete the information below and <u>bring this form with you</u>.

Name, phone #, and location of preferred pharmacy ______________________________

____

Do you have any allergies and if so, to what? ______________________________

____

As part of our electronic medical record we are able to pull your pharmacy records.
Are we permitted to obtain your pharmacy records? ❑ YES ❑ NO

List all current medications that you currently take, including vitamins, over-the-counter medications and herbal preparations.

Medication Name (Please Print Legibly)	Dosage (mg)	Frequency (How often per day)	Last Dose Taken	Check if need refill

If more space is needed, please use the back of this form.

↓ This section to be completed by the Endocentre ↓

Medications Added After Procedure/Office Visit	Dose (mg)	Frequency (How often per day)
1.		
2.		

☐ Copy Given to Patient ____________
Initials

EndoCentre

POST GI PROCEDURE INSTRUCTIONS (PRE-SEDATION)

1) It is not unusual to experience a sore throat temporarily (EGD) or a gaseous feeling after the procedure (colonoscopy).

2) Continue to rest at home for the completion of the day. Do not return to work until tomorrow, unless otherwise instructed by your physician.

3) No driving today **(NO EXCEPTIONS),** or other activities that may be affected by your altered perception due to the medication you received at the time of your procedure. You must have a driver present in the facility before you will be discharged.

4) No alcoholic beverages, narcotics or tranquilizers for twenty-four (24) hours unless you have checked with your physician.

5) You may experience some soreness or redness at the site of the needle in your arm (IV). Should these symptoms persist or spread, contact your physician.

6) Symptoms to watch for and report to your physician:
    a. Severe abdominal pain or bloating
    b. Chills or fever occurring within twenty-four (24) hours after the procedure
    c. Pain in your chest
    d. Severe abdominal pain, persistent bloating, nausea or vomiting
    e. A large amount of rectal bleeding following a colonoscopy. A small amount of blood from the rectum is not serious, especially if hemorrhoids are present.

7) EGD, colonoscopy - Usually, there are no restrictions on the diet after these procedures unless specified by your own physician. In general, do not start eating or drinking until fully alert.

I, the undersigned, have read and understand the above instructions, before receiving any sedation.

______________________________ Patient Signature

____________________ Date

Endocentre of Baltimore
Endocentre at Quarterfield Station

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to ABC surgery center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at the Endocentre of Baltimore or Endocentre at Quarterfield Station may have an ownership interest in Endocentre of Baltimore or Endocentre at Quarterfield Station. The physician has given me the option to be treated at another facility/Center, which I have declined.
I wish to have my procedure/services performed at Endocentre of Baltimore or Endocentre at Quarterfield Station.

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Endocentre of Baltimore or Endocentre at Quarterfield Station has been made available to me. I have the right to obtain a paper copy upon request. Version 1A

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Endocentre of Baltimore or Endocentre at Quarterfield Station policies pertaining to ADVANCED DIRECTIVES prior to the date of the procedure. ADVANCED DIRECTIVES will not be honored within the Center.

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Endocentre of Baltimore or Endocentre at Quarterfield Station and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

I authorize the Endocentre to speak to no one__________ or Name:______________________________.

I authorize the Endocentre to leave detailed voice messages on my answering machine. ____Yes ____No

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

______________________________________ ______________________________________

Signature of Patient or Responsible Party Print Name

______________________________________ ______________________________________

Relationship to Patient Date Signed

WOODHOLME
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Patient Label

Consent for Anesthesia Services

I authorize the Anesthesia Provider, ___Anesthesia Provider Name___, to provide anesthesia services as part of my upcoming procedure.

I understand and agree that the primary method of anesthesia administration will be moderate sedation, monitored anesthesia care. This method has been discussed with me in terms that I can understand. If, in the course of treatment, conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

The risks associated with anesthesia include but are not limited to reactions to medications; worsening of a preexisting medical problem; swelling; bleeding; discomfort at the sight of injection; phlebitis or other damage to blood vessels; nerve damage; airway difficulties; infections and aspiration pneumonia. Drug reactions can include a rash, itching, burning, nausea, vomiting, dizziness, muscle aches, headache, emotional lability, hives, wheezing, prolonged recovery from anesthesia and, very rarely, shock or even death.

There is also a rare potential for serious complications including difficulties breathing which may result in the need for an artificial airway. Maintaining an airway may include placement of an oral or nasal airway or an endotracheal tube. Reactions to artificial airways include laryngospasm and wheezing, which require immediate corrective treatment. Manipulation of the airway may result in damage to caps, bridges or teeth. Some individuals experience a sore lip, gums, tongue, throat, or hoarseness. Very rarely, patients may develop a cardiac or respiratory arrest, anaphylactic shock, malignant hyperthermia or airway closure. These are true medical emergencies which can cause temporary or permanent brain damage or death.

I have been given the opportunity to ask questions about the anesthesia. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any procedure and anesthesia, and it is impossible for the physician to inform me of every possible complication. I believe that I have sufficient information to give this informed consent.

I understand the potential risks, benefits, and alternatives available to me. My questions have been answered and I accept this procedure.

_______________________________________ _____________________

Signature of patient or person authorized to consent for patient Date

Anesthesia Provider Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/responsible adult to ask questions.

_______________________________________ _____________________

Certified Registered Nurse Anesthetist Signature Date

EndoCentre

Patient Label

Authorization for and Consent to Procedure

(with anesthesia)

I consent to allow my physician, ___Physician Name___, and such other assisting physicians and healthcare personnel as requested by my physician to perform the following diagnostic/therapeutic procedures: Endoscopic examination and possible biopsy/polypectomy, cautery, injections, and/or dilatation if indicated.

❑ UPPER GI ENDOSCOPY (EGD): Examination of the esophagus, stomach, and duodenum.
❑ COLONOSCOPY: Examination of all or the major portion of the colon.
❑ FLEXIBLE SIGMOIDOSCOPY: Examination of the anus, rectum, and last part of the colon.
❑ ESOPHAGEAL pH CAPSULE: Attachment of capsule to esophageal wall to monitor pH level over 48 hours.
❑ HEMORRHOID BANDING: Stopping the hemorrhoid's blood supply by use of rubber bands.
❑ OTHER: ______________________________

My physician has explained to me the nature and purpose of the procedure that will be performed. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure. My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives to the procedure. The potential risks or complications of this procedure include infection, adverse reaction to medication, dental trauma, injury to organs, bleeding, cardio/respiratory complications, and death that are attendant to the performance of any procedure. In a small percentage of patients, a failure of diagnosis or a mis-diagnosis may result.

I understand that there are risks with any procedure, and it is impossible for the physician to inform me of every possible complication.

I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction.

I understand that anesthesia services are being provided by anesthesia provider and I will sign a separate consent form for those services.

In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I have been given the opportunity to ask questions about the procedure that will be performed. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives and I enter into this contract to consent to the procedure freely. ____________ (initial)

The undersigned certifies that he/she has read the foregoing and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

______________________________ ______________________________
Patient Signature or Patient Representative Signature / Relationship — Date

______________________________ ______________________________
Witness Signature (Employee) — Date

Physician Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the procedure and have allowed the patient/responsible adult to ask questions.

______________________________ ______________________________
Physician Signature — Date