A T T E N T I O N

P A T I E N T S

It is very important that you:

1) Review & read the entire patient packet we provided to you as soon as you get home.
2) If you have any questions call our office at 410-602-7782 so that we can address your concerns.
3) Sign, but **DO NOT DATE** the documents.
4) Bring the documents with you the day of the procedure.

Colonoscopy Prep Instructions

1) We will send a prescription for the Prep Kit to your pharmacy the same day we scheduled your procedure.
2) Pick the Prep Kit up immediately.
3) If you do not pick up the Prep Kit immediately the pharmacy may cancel the order.
4) Follow the Prep instructions that are located within the envelope we gave to you. **Do NOT follow the instructions on the box.**

Failure to follow the instructions provided in the packet may result in cancellation of your procedure.

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GASTROENTEROLOGY ASSOCIATES
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5 DAYS BEFORE YOUR PROCEDURE:

1. STOP Iron tablets 1 week before your procedure.
2. STOP Phenteramine, and other weight reduction medications 1 week before your procedure.
3. It is critical that you notify the doctor if you take **Aspirin, Plavix, Coumadin (Warfarin), Effient, Pradaxa, Eliquis or Xarelto.**
4. FOR YOUR COLONOSCOPY—DO NOT eat: corn of any kind, raw fruits, nuts, raw vegetables, or fiber supplements 3 days before your procedure.
5. All GLP-1 agnoists must be stopped 7 days prior. These medications are often prescribed for diabetes or weight loss. These medications include but are not limited to: **Phentermine, Tenuate, Diethylpropion, Amfepramone, Meridian, Sibutaramine, Ozempic, Trulicity, Victoza, Saxenda, Rybelsus, Mounjaro.** If you are unsure please contact the office.

THE DAY BEFORE YOUR COLONOSCOPY:

1. Do not have: solid foods, milk or milk products.
2. You are to have only **CLEAR Liquids** with no Red dye. Clear liquids include: water, broth, **black coffee**, or **black tea** (no creamers), and Gatorade. You may have Jell-O, clear soda, and popsicles so long as they are not colored red.
3. Drink 6-8 glasses of water starting 8AM until 5PM to get yourself well hydrated.

PLEASE SEE THE INSTRUCTIONS ON HOW TO TAKE YOUR BOWEL PREP SOLUTION

DAY OF THE PROCEDURE (Colonoscopy 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. *You must have someone to drive you home because you will be receiving intravenous sedatives.*
4. If on blood pressure, seizure, anxiety or thyroid medications please take at least 2 hours before your procedure 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.
8. DO NOT Smoke the day of your procedure.

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 A
Glen Burnie, MD 21061
Phone: 410-863-4899

Endocentre of Westminster
535 Old Westminster Pike
Suite 104
Westminster, MD 21157
Phone: 410-602-7782

Medication List

Name _____ Date of Birth _____ Today's Date _____

Reason for Visit _____

Please complete the information below and bring this form with you.

Name, phone #, and location of preferred pharmacy _____

_____

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

_____

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

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

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Additional Information

1. 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 be able to be reached and confirmed prior to your procedure start. Please bring their phone number with you. We will ask that they not wait in the suite with you. You may not drive following your procedure.
2. If you have been prescribed an inhaler for asthma, PLEASE BRING THE INHALER WITH YOU, EVEN IF YOU RARELY USE IT.
3. PLEASE BRING ALL INSURANCE CARDS AND PICTURE ID WITH YOU.
4. Please do not wear jewelry or bring any valuables with you the day of the procedure. We are not responsible for the loss or damage to any valuables, jewelry or belongings.

Procedure Cost

The cost of your procedure is dependent on your specific health insurance plan and your coverage benefits.

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 may receive 3 bills—the facility, the professional staff (MD, Anesthesia, Pathologist) and any laboratory or pathology tests.

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.

Thank you.

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

_____ _____

Signature Date

Please see the reverse side for Prep Instructions

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POST GI PROCEDURE INSTRUCTIONS (PRE-SEDATION)

1) It is not unusual to experience a sore throat temporarily (EGO) 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 responsible adult with you, to escort and drive you home, following the procedure Your responsible adult must be able to be reached and confirmed prior to your procedure start. Please bring their phone number with you. They will be asked not to wait in the suite.

   Responsible Driver Name:_____ Phone Number:_____

   Emergency Contact Name:_____ Phone Number:_____

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) EGO, 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
Endocentre of Westminster

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 the Endocentre of Baltimore, Endocentre at Quarterfield Station, Endocentre of Westminster, 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, Endocentre at Quarterfield Station, or Endocentre of Westminster may have an ownership interest in Endocentre of Baltimore, Endocentre at Quarterfield Station, or Endocentre of Westminster. 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, Endocentre at Quarterfield Station, or Endocentre of Westminster.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Endocentre of Baltimore, Endocentre at Quarterfield Station, or Endocentre of Westminster 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, Endocentre at Quarterfield Station, or Endocentre of Westminster 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, Endocentre at Quarterfield Station, Endocentre of Westminster, 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

EndoCentre

AUTHORIZATION FOR AND CONSENT TO PROCEDURE

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I consent to allow my physician, _____, and such other assisting physicians and surgical personnel as requested by my physician to perform the following surgery or procedure:

- UPPER GI ENDOSCOPY (EGD): Examination of the esophagus, stomach, and duodenum with possible biopsy.
- COLONOSCOPY: Examination of all or the major portion of the colon with possible biopsy/polypectomy.
- 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 surgery or procedure. The potential risks or complications of this procedure include infection; aspiration; adverse reaction to medication; infection, phlebitis, and/or nerve injury related to the IV catheter; injury to organs; bleeding; perforation; cardio/respiratory complications; and death. Patients with previous abdominal/pelvic surgery and those with extensive diverticulosis may be at higher risk for complications. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result.

Teeth and/or dental prosthetics (such as dental implants, veneers, caps, crowns, and bridges) may become loose, broken, or dislodged, especially if loose or in poor repair regardless of the care provided. By signing this consent, you are acknowledging that neither your physician, anesthesia provider, nor the facility will be responsible for any dental damage or repair costs.

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

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the surgeries or procedures to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, to be in attendance during my surgery or procedure if the situation arises.

I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist and the like are independent practitioners exercising their independent clinical judgment. They are not employees or representatives (agents) of the surgery center. I understand that anesthesia services are being provided by Woodholme Gastroenterology and I will sign a separate consent form for those services.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the surgery or procedure.

I have been given an 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 surgery or procedure freely. I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction.

I attest that I am 18 years of age or older, my judgment is not impaired by any legal or illegal substance, and I am signing this consent of my own free will and have not been forced by any person to consent to this procedure. 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.

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.

_____ _____

Patient Signature or Patient Representative Signature / Relationship Date

_____ _____

Nurse's Signature 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

Translation Services

_____ Translation services have been utilized.

This consent has been verbally translated into _____ for the benefit of the patient/patient's representative who understands this language better than English.

_____ _____ _____

Translator's ID Number and/or Name Translator's Signature (If Onsite) Date/Time

_____ Translation services provided using Cryacom

_____Translation services provided by person accompanying patient

WOODHOLME
GASTROENTEROLOGY ASSOCIATES
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CONSENT FOR ANESTHESIA SERVICES

You, in consultation with your physician, have decided to undergo a procedure that requires anesthesia. Your anesthesia provider has explained your anesthetic options, medically acceptable alternatives, and the substantial and material risks and benefits of the proposed anesthesia. IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS CONSENT FORM CAREFULLY (or have it read to you) and that you ask questions about any information that you may not fully understand.

MAC (MONITORED ANESTHESIA CARE) IV ANESTHESIA WITH/WITHOUT SEDATION: Your anesthesia provider will monitor you and may provide ***sedation*** by administering intravenous (injected through a catheter into your bloodstream) drugs to calm your anxiety and produce a semi-conscious state. Your level of sedation may vary from light to deep, depending on your response to the medications and your clinical needs. The intended plan for anesthesia is Deep Sedation. Deep Sedation is a drug-induced depression of consciousness during which you cannot be easily aroused. While receiving anesthesia with or without sedation, you may be aware of your surroundings, may be able to hear and respond to your medical providers and/or may remember some or all of the procedure. Although rare, your level of sedation may unintentionally progress to general anesthesia, depending on your response to the medications given. Rarely, MAC cannot provide adequate relief or the medications used to sedate you may severely depress (lower) your breathing or slow your heart rate, requiring use of general anesthesia.

GENERAL ANESTHESIA: General anesthesia involves the use of intravenous (injected through a catheter into your bloodstream) medications to achieve a total unconscious state. This may involve the use of a breathing tube, which is inserted through your mouth or nose into the windpipe to ensure proper breathing while you are unconscious.

All forms of anesthesia involve some risks. No guarantees or promises can be made that you will not suffer a side effect or complication from your anesthesia. The determination of what type(s) of anesthesia are best for you depend on many factors including your physical condition, the type of procedure you are undergoing and the preferences of you and your physician. Rare, unexpected and severe complications can occur with all forms of anesthesia, including infection; *drug or allergic reactions; nerve injury with loss of sensation or function; paralysis; stroke; bleeding; blood clots; damage to liver, kidney, lungs; heart attack; brain damage and even death.* Common side effects and specific complications of particular types of anesthesia include, but are not limited to those identified below.

Risks and common side effects of sedation/anesthesia include:

- Nausea and/or vomiting
- Mild to moderate decreases in blood pressure and/or heart rate
- Injuries to the mouth, lips and surrounding areas
- Aspiration (inhaling stomach contents into the lungs), asthma attacks, and pneumonia (lung infection and/or swelling)
- Convulsion/seizure
- Swelling, tenderness, bleeding and bruising at injection site
- Infection, swelling or other damage to blood vessels
- Soreness of the throat and hoarseness
- Nodules, polyps, or other damage to the vocal cords or windpipe
- Esophageal injury from gastric (stomach) tubes and/or esophageal dilators
- Rarely, there can be awareness under anesthesia and dreams during anesthesia may be confused with recall of real events.

Teeth and dental prosthetics (such as dental implants, veneers, caps, crowns, and bridges) may become loose, broken, or dislodged, regardless of the care provided. By signing this consent, you are acknowledging that neither your anesthesia providers, physician, the facility, nor the company employing or engaging the anesthesia providers will be responsible for any dental damage or repair costs.

In order to minimize the possibility of aspiration, the patient is required not to eat or drink anything for a period of time before the procedure. It is extremely important not to eat or drink anything during this time because aspiration of food or stomach contents can lead to severe pneumonia, respiratory failure, and death.

Independent Practitioners: Anesthesia services are being provided by Woodholme Gastroenterology.

I understand and agree that the anesthesia providers who furnish services to me are independent practitioners exercising their independent clinical judgment. They **are not employees or representatives (agents) of the surgery center.**

I understand that the administration of anesthesia will be supplied by, or under the direction and responsibility of, the anesthesia providers, which may include anesthesiologists, certified registered nurse anesthetists (CRNAs), and from time to time, other healthcare professionals in training may be involved in my care and treatment.

By signing below, I HEREBY CERTIFY that I have read this consent form (or had it read to me) and that my anesthesia provider, Woodholme Gastroenterology has fully explained it to me. I have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand the intended anesthesia plan of care is Deep Sedation. I understand my anesthetic options, alternatives, and the substantial and material risks and benefits of the proposed anesthesia. **I do hereby consent** to the administration of my chosen anesthesia, or changes to the plan as may be considered necessary or advisable.

I attest that I am 18 years of age or older, my judgment is not impaired by any legal or illegal substance, and I am signing this consent of my own free will and have not been forced by any person to consent to this procedure.

Signature of Patient or Authorized Patient Representative	Nurse's Signature	Date

Anesthesia Statement

I certify that I have explained to the patient (parent/Authorized Representative) the anesthesia options and medically acceptable alternatives, the material or substantial risks and benefits (both short and long-term) and have allowed the patient (Parent/Authorized Representative) to ask questions.

Signature of Anesthesia Provider	Date