ATTENTION

If, after reading your pre-procedure information packet, you have **ANY** questions, please contact our staff at 615-250-4108, option 4.

You ABSOLUTELY must bring an adult (18 years or older) that can remain in the waiting room **or** on the hospital premises the entire time you are at this facility and can also drive you home.

This is for your safety and due to the fact that you will be sedated.

IF you do not bring someone that will stay in the facility or on the hospital campus throughout the entire time you are here,

WE WILL BE FORCED TO RESCHEDULE YOUR PROCEDURE!

This policy is solely in the interest of your safety and well being.

****

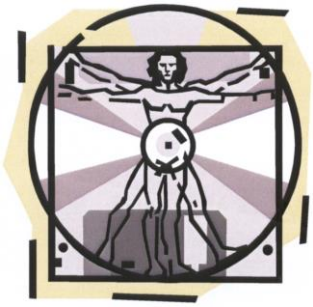
Attention:

If your medications change between the time your procedure is scheduled and the actual date of your procedure, please call our office immediately so we may assess these changes and their possible effect on the safety of your procedure.

PLEASE complete the Patient Screening Checklist, the Medication Reconciliation Form and sign the last two forms in this packet.

* * * Please disregard any email from St. Thomas Medical Group regarding your arrival time.

COLONOSCOPY



THE ENDOSCOPY CENTER OF ST. THOMAS

4230 Harding Pike

St. Thomas Medical Plaza East
Suite 400
Nashville, TN. 37205
(615) 250-4108 option 4

www.stmgendo.com

JEFFREY B. ESKIND, M.D.

Your appointment has been scheduled for:

_____ _____

Date Time of **Arrival**

(This is not your procedure time.)

Included in the packet below is the information you will need to be prepared for your appointment at the Endoscopy Center.

Enclosed are instructions regarding what to purchase for your preparation, how to prepare for your colonoscopy and general information about the procedure and our center.

Please read the ENTIRE packet carefully.

The Endoscopy Center of St. Thomas
Gatorade G2 / Miralax Split Dosing Preparation for Colonoscopy

Name_____ Date of Procedure _____

Purchase for preparation: Two 32-ounce bottles of Gatorade **(NOT RED, ORANGE, OR PURPLE)**
Two 119 gram bottles of Miralax
Two Dulcolax (bisacodyl) tablets (laxative NOT stool softener)

(If you have difficulty locating these items, please ask your pharmacist for assistance.)

(If you are diabetic, you may use Gatorade Zero to aid in blood sugar control while taking preparation.)

The Day Before Your Procedure: _____

YOU MUST NOT EAT ANY SOLID FOODS FROM THE TIME YOU GET UP TODAY UNTIL AFTER YOUR COLONOSCOPY.

- Refrigerate Gatorade/ Gatorade Zero early in the morning.
- Drink only clear liquids today.
- A clear liquid diet consists of broth, bouillon, tea, black coffee (no milk, cream or creamer), sodas, apple juice, Popsicles, Jell-o, Gatorade, etc. If you can see through it you can drink it**. Do not have anything with red or orange dye**. **NO orange, tomato or purple grape juice** (white grape juice is allowed).
- **At 10 am** take two Dulcolax (bisacodyl) tablets.
- **At 12 noon** mix one 119 gram bottle of Miralax powder in 32 ounces of cold Gatorade.
- Shake bottle of Gatorade//Miralax solution thoroughly until Miralax is dissolved. Start drinking one 8-ounce glass of solution every 20 minutes until bottle is empty. Keep bottle of solution cold in refrigerator or on ice. (Save other bottle of Miralax powder to mix at 8 pm with second bottle of Gatorade for second dose of preparation.)
- This is a bowel cleansing preparation and will cause you to have diarrhea. You may continue to drink clear liquids until bedtime. **REMEMBER**, NO SOLID FOODS.
- **At 8 pm** mix one 119 gram bottle of Miralax powder in 32 ounces of cold Gatorade.
  Shake bottle of Gatorade/Miralax solution thoroughly until Miralax is dissolved. Start drinking one 8-ounce glass of solution every 20 minutes until bottle is empty. Keep bottle of solution cold in refrigerator or on ice.

Remember: NO SOLID FOODS.

YOU MAY CONTINUE TO HAVE CLEAR LIQUIDS UNTIL MIDNIGHT!

THE MORNING OF YOUR COLONOSCOPY~~ DO NOT HAVE ANYTHING TO EAT OR DRINK AFTER MIDNIGHT. THIS INCLUDES GUM AND MINTS.

Please be sure to follow the medication instructions on page 5 of this packet.

You *must* have a responsible adult accompany you to your procedure to drive you home. The driver must be able to stay in the waiting room while you are here. You cannot drive or work until the morning after your procedure due to the sedation you will receive. If you do not bring a driver with you, your procedure will **be cancelled.**

Please call (615) 250-4108 option 4 with any questions or concerns. If you have questions the morning of the procedure, please call 615-250-4105 after 6 am.

** *ATTENTION:* **

If you have undergone any test which you were required to drink BARIUM or if a barium product was used within 3 days prior to your scheduled colonoscopy, *DO NOT* begin your prep!!

Your colonoscopy results **MAY NOT BE ACCURATE** because the barium interferes with visualization of the colon.

Please call our office at once during **REGULAR** business hours.

We will be happy to reschedule your colonoscopy at your convenience.

PLEASE UNDERSTAND

YOU ***MUST*** BRING A RESPONSIBLE ADULT TO STAY IN THE WAITING ROOM AND DRIVE YOU HOME OR YOUR PROCEDURE WILL BE CANCELLED.

****Hydration is part of your prep! Please drink at least 8 oz. clear liquids every hour throughout the day on the day prior to starting your preparation, unless prohibited by a previous medical condition.**

DO NOT EAT ANY SOLID FOOD THE DAY BEFORE YOUR PROCEDURE.

YOU MAY ***ONLY HAVE CLEAR LIQUIDS***.

NO SOLID FOOD ALL DAY!!

No red, orange, or purple liquids.

BLACK COFFEE ONLY! No cream.

CLEAR LIQUIDS ONLY… ALL DAY!!

YOU MUST HAVE *NOTHING* TO EAT OR DRINK AFTER MIDNIGHT THE MORNING OF YOUR PROCEDURE . THIS INCLUDES GUM AND MINTS!

NO MINTS

NO GUM

NOTHING TO DRINK OF ANY KIND

ABOUT YOUR MEDICATION

Alerts and Adjustments Needed for your Procedure

PLEASE READ THIS CAREFULLY!

YOUR SAFETY AND WELL BEING DEPENDS ON THIS!

Failure to read and follow these directions can result in serious complications.

If you take medication for **any** of the following conditions (***blood pressure, seizures, respiratory issues***), please continue these medications as directed by your prescribing physician.

Do not stop these medications for any reason!

The morning of your procedure, take these medications with enough sips of water to completely swallow them.

- Blood pressure medication
- Seizure medication
- Inhaler (Please bring your inhaler with you to the Endoscopy Center on the day of your procedure.)

➢ **If you are Diabetic (take medication for your blood sugar):**

If you take diabetic medications or insulin, please bring your medication with you the day of the procedure. If you use an insulin pump, turn it off at midnight before your procedure.

If you take regular insulin injections ***or*** concentrated insulins such as Humalog, Regular U-500, Lantus, Tresiba, etc, please check with your prescriber to evaluate how to adjust your specific medication needs. Since your normal dietary intake will be stopped due to preparation for your procedure, there will be an increased possibility of unexpected blood sugar fluctuations. Adjustments of dosing during preparation and when to hold your insulin on the day of procedure will vary depending on your individual medical status.

➢ **If you take blood thinning medications:**

Blood thinning medications **must be stopped or adjusted** per the needs of the individual patient.

➢ **Xarelto, Pradaxa, Eliquis, Brilinta and Effient MUST be stopped 2 days prior to your procedure. NO EXCEPTIONS. This adjustment must be approved by your prescribing physician prior to the day of your procedure.**

Stop or adjust the medications listed below:

Medication	Adjustment required	Further Details /Instructions
Aspirin (any meds containing aspirin)	Stop 7 days prior to procedure	Unless prescribing physician instructs NOT to stop
NSAIDS (prescribed or over the counter)	Stop 7 days prior to procedure	Including ibuprofen, Advil, Aleve, Celebrex, Naprosyn
Aspirin taken with Plavix (clopidogrel)	Must stop ONE 7 days prior	
Coumadin (warfarin)	Stop 5 days prior to procedure	

Other medications to be stopped include: persantine, dipyridamole, fish oil, multi-vitamins, vitamin E, heparin, Ticlid and iron.

This is not an all-inclusive list. Please consult your prescribing physician.

If your PCP or cardiologist does not approve of discontinuing your **Coumadin** or **one** of the **Plavix/Aspirin** combination medications for 7 days, we can perform the procedure but we **CANNOT TAKE ANY BIOPSIES, REMOVE POLYPS, OR UNDERTAKE ANY OTHER THERAPEAUTIC INTERVENTIONS DURING YOUR PROCEDURE.**

The timing for resuming your anticoagulation therapy after your procedure may be altered due to findings related to your procedure. The physician will give you specific medication instructions at discharge.

Avoid endoscopic procedures in the first 30 days following placement of a cardiac stent, except for a declared emergency!

The morning of your procedure, *from midnight until your arrival time*:

Do not smoke or dip.

No electronic cigarettes or vaporizer inhalation.

Do not chew gum, have mints or cough drops, eat or drink.

THE ENDOSCOPY CENTER

The doctors, nurses, and staff of the Endoscopy Center of St. Thomas appreciate the confidence you have placed in us. You have chosen one of the finest facilities of its kind in the nation for your medical care and treatment. The facility is staffed with certified registered nurse anesthetists (CRNA) for all cases, providing a safe and comfortable environment for your outpatient procedure. We have always been dedicated to creating a true center of excellence in endoscopy for our patients. Our attention to detail and individualized patient care, as well as our use of advanced technology, has kept us in the forefront of endoscopy centers. We want you to be completely satisfied that the care you receive in the Endoscopy Center is of the highest quality. Our staff would be glad to answer any questions before a service is rendered.

The Endoscopy Center has received certification from Medicare as well as the Tennessee Board for Licensing Health Care Facilities. In addition, major insurance providers have approved our facility for its outstanding service, safety, and cost benefit.

WHAT IS A COLONOSCOPY?

A colonoscopy is an examination of the rectum and large intestine. A long flexible tube, about the thickness of a finger, is inserted through the rectum into the large intestine (colon). This allows the physician to carefully examine the lining of the colon, and identify any abnormalities which may be too small to be seen on x-ray.

A colonoscopy is used to diagnose cancer, colitis, polyps, causes of bleeding, and abnormal or questionable
x-rays. If your physician sees an area of inflammation, he can pass an instrument through the colonoscope and take a small piece of tissue (biopsy) for examination. Also, if polyps are found during the procedure, they can be removed and sent to pathology.

PREPARATION

- The **entire day before your colonoscopy**, you must remain on a clear liquid diet which can include: Gatorade, Tea, Coffee (without cream), Water, Apple Juice, Popsicles, White Grape Juice, Coke or 7Up, Chicken/Beef Broth, Jell-O (except red, grape and orange). **No orange, tomato or grape juice. Avoid milk products or any items containing red, orange, or purple dye.**

You ***MUST*** cleanse your colon to be adequately prepared for your colonoscopy.

Your physician will prescribe a colon cleansing preparation individualized for your specific medical needs.

Please refer to page 3 of this packet for the instruction sheet chosen for you detailing complete directions explaining the procedure to cleanse and prepare your colon for your procedure.

Your stool should become tea colored, yellow or clear. Please continue to drink your laxative as instructed until container is empty.

Tips for Preparation Tolerance: Walk around, stay active; Drink prep with a straw if necessary; Follow glass of prep with another liquid or bite of a lemon to cleanse your palate; Drink warm liquids. *Please notify the office with any difficulties you have with drinking your bowel cleansing preparation.

- Please notify the office if you have a pacemaker, internal defibrillator or if there is any chance of pregnancy.
- You may brush your teeth. Wear comfortable clothing.
- Leave all valuables (i.e. jewelry) at home. We cannot assume responsibility for lost or misplaced items.
- **Please bring an updated list of your current medications or bring all of your medications for review.**
- Please bring your insurance cards and photo identification card with you.

FOLLOW INSTRUCTIONS CAREFULLY.

If you do not, the procedure may need to be re-scheduled or cancelled.

You must arrange for a relative or friend to accompany you and drive you home or your appointment will be rescheduled. This person must be at least 18 yrs old and must remain in the waiting area during your procedure. You can expect to be here for approximately 2 hours. Even though you may not feel that you are affected by the sedation, your judgment and reflexes may not be normal. We recommend that you do not work or drive until the day following your procedure. You are considered legally intoxicated until the morning following your procedure.

6

PROCEDURE

You will receive an intravenous medication which will help you to relax for the procedure. You will lie comfortably on your left side during the procedure while the scope is inserted through the rectum until the colon is clearly visible for inspection. Air is pumped into the bowel to keep it open so the scope moves easily. Biopsies of tissue and polyps can easily be removed as needed. The entire procedure usually takes only 15 to 20 minutes. The air that is put in the bowel may cause some abdominal cramping or a bloated feeling. This will disappear within 24 hours. The biopsy causes no pain or side effects.

CANCELLATION POLICY: ***Please give a 24-hour notice in the event you need to cancel your scheduled procedure by calling (615) 250-4108, option 4. A broken appointment is a loss to everyone. This allows us to offer this time to someone else. If you do not cancel your appointment within this time frame, you may be assessed an administrative fee of $200.00.***

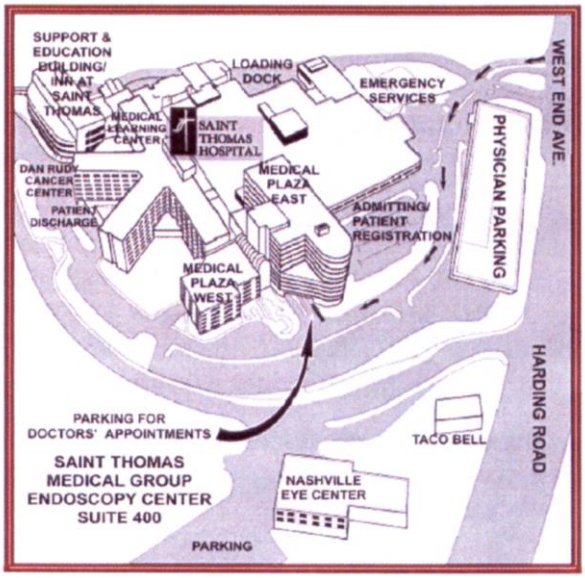
RESULTS

Your doctor will discuss the colonoscopy results with you after your procedure. If a biopsy or polypectomy was performed, allow at least 10-14 days for your results.

As you may or may not be aware, the HIPAA (Health Insurance Portability and Accountability Act) precludes us from disclosing any information regarding your personal health information to any person other than yourself or your court appointed guardian. If there is someone else with whom you would like us to share the results of your test, you will need to make that known to us in writing. This includes your spouse and children.

QUESTIONS? PLEASE CALL (615) 250-4108 option 4

If directions to the Endoscopy Center of St. Thomas are needed please call us at (615) 250- 4108, option 4 or visit our website at www.stmgendo.com.



ADVANCED DIRECTIVES

Do you have an advanced directive for healthcare which specifies your choice for medical care as well as a written directive designating a person to make healthcare decisions for you if you are unable to make these decisions?

If you have an **ADVANCED DIRECTIVE*, please bring a copy with you on the day of your procedure.*** You will need to speak with your Doctor to discuss your treatment plan.
PLEASE READ THE PARAGRAPH BELOW CAREFULLY. IF YOU HAVE ANY QUESTIONS PRIOR TO THE DAY OF YOUR PROCEDURE, PLEASE CALL OUR OFFICE SO THEY CAN BE ADDRESSED APPROPRIATELY.

The Endoscopy Center of St. Thomas respects the right of patients to make informed decisions regarding their care. If you become unable to make a decision regarding your own care, Center staff will consult the Advanced Directives, medical power of attorney, or patient representative or surrogate, if available. Due to the outpatient nature of an Endoscopy Center, this Center has adopted the position that an ambulatory procedure setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this center **THAT IN THE ABSENCE OF AN APPLICABLE PROPERLY EXECUTED ADVANCED DIRECTIVE,** if there is deterioration in your condition during treatment at the center, the personnel at the center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital. At the acute care hospital, further treatment decisions will be made. If copies of your Advanced Directives have been provided to the center, copies will be sent with you to the hospital.
If you have Advanced Directives which have been provided to the center that impact resuscitative measures being taken, we will discuss the treatment plan with you and your physician to determine the appropriate course of action to be taken regarding your care and the appropriate setting in which your care should administered.

THE ENDOSCOPY CENTER PATIENT SCREENING CHECKLIST

Patient's Name: _____ Age: _____

Referred by: _____ DOB: _____

Have you ever seen a doctor in St. Thomas Medical Group? ____Yes Dr. _____ No_____

Have you ever had this test before? _____Yes _____No By Whom?_____

What are your symptoms? How Long?_____

Do you bleed easily (free bleeder)?……___Yes ___ No

If you take blood thinners, did you stop prior to this procedure?_____Yes When?_____ No ___

As instructed, I have consulted with and received instruction from the physician managing my blood thinning medications (anticoagulants) with regard to this procedure._____**(Pt. Initials)**

Physician's Name_____

Do you have difficulty with urination?…….___ Yes ___ No

ANY chance of pregnancy? …….……..__ Yes ___ No

Date of last menstrual period _____

Do you have glaucoma? …….. ___ Yes ___ No

Do you take medication for sleep / nerves? …___Yes___ No

Do you drink alcoholic beverages? …….……__ Yes ___ No

If so, how much? _____

Do you have breathing problems, sleep apnea, or use oxygen / CPAP?……___Yes ___No

If yes, explain: _____

ANY history of tobacco/Vape use? Yes /No Currently or in the past? How much and how long? _____

Do you have a personal or family history of colon polyps? Yes / No If Yes, who? _____

Do you have a personal or family history of cancer? __Yes __No If yes, who and what kind?_____

Any history of blood transfusions, hepatitis, or communicable diseases? Yes ___ No ___ If yes, explain:

Medical History

1) Coronary artery disease…….___Yes ___No

2) Bypass surgery / valve replacement or repair __Yes __No

3) Heart failure (CHF) …… ___Yes ___No

4) Angioplasty or stent placement…..……...___Yes___ No

when:_____

5) High blood pressure…...…….……____Yes ___No

6) Diabetes ……...___Yes ___No

7) Stroke/ TIA……___Yes ___No

8) Seizures…….___Yes ___No

9) Any underlying medical conditions: _____

_____

_____

_____

_____

List all surgeries you have had below:

1)_____

2)_____

3)_____

4)_____

5)_____

Please complete the attached medication form.

An accurate listing of your current medications is very important to provide the best possible care while having your procedure.

This form needs to be filled out completely before your arrival in the center.

Person responsible for your transportation home:

Name:_____Phone Number ( ) - Relationship_____

(THIS PERSON MUST REMAIN IN THE WAITING ROOM DURING YOUR PROCEDURE.)

_____ _____

Patient Signature Date

Medication Reconciliation Form

Patient's Name: ____ **DOB**: ____________________

Pharmacy: ____________________ **Pharmacy Phone**: ____________ **Pharm. Address**:______________

Drug Allergy	Reaction		**Drug Allergy**	Reaction

Current Prescription Medications **(For Office Use Only)**

Name of medication	Dose	Frequency	When did you take your last dose?	***AFTER DISCHARGE***: Continue	**STOP**	Additional Instructions

Herbals, Vitamins, Supplements, Non-prescription Medications **(For Office Use Only)**

Name of medication	Dose	Frequency	When did you take your last dose?	***AFTER DISCHARGE***: Continue	**STOP**	Additional Instructions

Signature of person completing form: ___________________________________Date: ________________

****

AFTER DISCHARGE FROM THE ENDOSCOPY CENTER:

New medications or changes to existing medications (See listing below) **OR** NO CHANGES THIS VISIT __

Medication	Dose	Frequency	Reason for medication

Date: ________________ Signature of patient's responsible party: ________________________

Nurse signature: _______________________________ Physician Signature: _________________________

The Endoscopy Center of St. Thomas

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 deductibles, 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 Endoscopy Center of St. Thomas, 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 Endoscopy Center of St. Thomas may have an ownership interest in The Endoscopy Center of St. Thomas. I have been provided a list of physicians who have a financial interest or ownership in the Center. 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 The Endoscopy Center of St. Thomas.

CERTIFICATION OF PATIENT INFOMATION

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

Email/ Text/ Automated Communication Informed Consent

I hereby consent and authorize The Endoscopy Center of St. Thomas, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors , and other contracted parties, to use automated telephone dialing systems, text messaging systems and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to

Patient Signature	Date Signed	Printed Name
Patient/Guardian Signature (if patient is a minor)	Date Signed	Printed Name

medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Contact Information: Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from The Endoscopy Center of St. Thomas, you may unsubscribe by replying and entering "Unsubscribe". If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

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 policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

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

Signature of Patient or Responsible Party	Print Name
Relationship to Patient	Date Signed

Billing Procedures for The Endoscopy Center of St. Thomas

The Endoscopy Center of St. Thomas Billing Office will inform you of any deductible and co-pays you may owe at the time of service. We accept a wide variety of payment options including cash, check, MasterCard and VISA. It may also be possible to make other financial arrangements if you are unable to make payment in full at the time of service.

NOTE: You will receive at least three separate statements for your procedure.

1. One of the statements will be addressed from St. Thomas Medical Group/ ADI. This bill is a result of the professional services provided to you. This is the fee the doctor has charged for doing the procedure. Our office will bill your insurance company for the charges. However, during this time period, you will continue to receive a statement. Please make arrangements to pay the portion that is not covered by your insurance company as soon as you receive your first statement. Once your insurance company has paid, it will be reflected on your next statement.
2. Another statement will be addressed from the Endoscopy Center of St. Thomas. This bill is a result of the facility fee and takes the place of an outpatient hospital bill. The facility is state licensed and certified by Medicare as an Ambulatory Surgery Center. Your insurance company will be billed separately for these charges. However, during this period, you will continue to receive a statement. Please make arrangements to pay the portion that is not covered by your insurance company the day of service. Once your insurance company has paid, it will be reflected on your next statement.
3. The third bill will be from GF Medical Solutions, PLC or Nashville Gastro Anesthesia (NGA) for the anesthesia provided during your procedure.
4. There may be other statements sent to you by a lab and pathologist due to biopsies obtained during your procedure. Their billing procedures may differ from the three above. You will need to contact the number on your statement for any question you may have regarding their billing procedures.

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

Date_____ _____

Printed Name

_____

Signature of Patient / Guardian