

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.

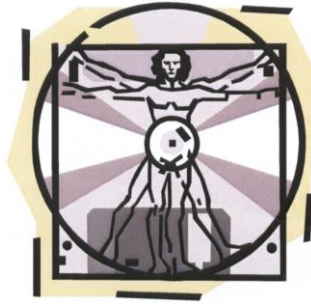
Attention:

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.

EGD



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 is general information about the procedure and our center.

You will have several forms to sign on arrival to the center, including medical history and medication lists.

Please read the **ENTIRE** packet carefully.

THE ENDOSCOPY CENTER

The doctor's, 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. 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 you may have 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 AN EGD?

An EsophagoGastroDuodenoscopy (EGD) is a procedure that enables your physician to examine your upper digestive tract. The physician inserts the endoscope, a long flexible, lighted tube, about the thickness of your little finger, through the mouth into back of the throat. This allows him to examine the lining of the esophagus, stomach and duodenum (the first portion of the small intestine).

Abnormalities suspected by X-ray can be confirmed and others which may be too small to be seen on X-ray can be detected. If your physician detects an area of inflammation, he can pass an instrument through the endoscope and take a small piece of tissue (biopsy) for examination in the laboratory. Biopsies are taken for many reasons and do not necessarily imply cancer.

PREPARATION

DO NOT EAT OR DRINK ANYTHING past midnight the morning of your scheduled EGD.
This includes **ALL LIQUIDS**, gum, mints, hard candy, etc.



Please...AFTER MIDNIGHT the morning of your procedure: Do not smoke or dip.
No electronic cigarettes or vaporizer inhalation.

- Please notify the office if you have a pacemaker, internal defibrillator, or if there is any chance of pregnancy.
- You may brush your teeth. IF you wear dentures, do not secure them. They will be removed for the procedure.
- Wear comfortable clothing.
- Please bring your insurance cards, photo identification and an updated list of your current medications with you.
- Leave all valuables (i.e. jewelry) at home. We cannot assume responsibility for lost or misplaced items.

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 THERAPEUTIC 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.**

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.

PROCEDURE

Your physician will give you an intravenous medication which will help you to relax for the procedure. While lying on your left side in a comfortable position, the endoscope is inserted through the mouth and each part of the esophagus, stomach and duodenum is examined. The procedure usually lasts 15-20 minutes.

The procedure is well tolerated with little or no discomfort. The endoscope does not interfere with breathing.

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

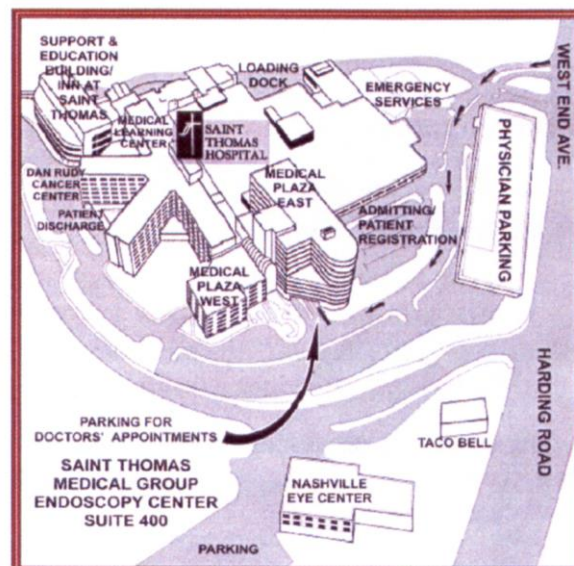
Your doctor will discuss the endoscopy results with you after your procedure. If a biopsy or polypectomy was performed, allow at least 10-14 days for your results.

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.

St Thomas Medical Group Endoscopy Center 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? _____

<p>Do you bleed easily (free bleeder)?.....__ Yes __ No</p> <p>If you take blood thinners, did you stop prior to this procedure? ____ Yes When? _____ No ____</p> <p>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)</p> <p>Physician's Name _____</p> <p>Do you have difficulty with urination?.....__ Yes __ No</p> <p>ANY chance of pregnancy?__ Yes __ No</p> <p>Date of last menstrual period _____</p> <p>Do you have glaucoma?__ Yes __ No</p> <p>Do you take medication for sleep / nerves? ...__ Yes __ No</p> <p>Do you drink alcoholic beverages?__ Yes __ No</p> <p>If so, how much? _____</p> <p>Do you have breathing problems, sleep apnea, or use oxygen / CPAP?.....__ Yes __ No</p> <p>If yes, explain: _____</p> <p>ANY history of tobacco/Vape use? Yes /No Currently or in the past? How much and how long? _____</p> <p>Do you have a personal or family history of colon polyps? Yes / No If Yes, who? _____</p> <p>Do you have a personal or family history of cancer? ____ Yes __ No If yes, who and what kind? _____</p> <p>Any history of blood transfusions, hepatitis, or communicable</p>	<p>Medical History</p> <p>1) Coronary artery disease.....__ Yes __ No</p> <p>2) Bypass surgery / valve replacement or repair ____ Yes ____ No</p> <p>3) Heart failure (CHF)__ Yes __ No</p> <p>4) Angioplasty or stent placement.....__ Yes __ No</p> <p>when: _____</p> <p>5) High blood pressure.....__ Yes __ No</p> <p>6) Diabetes__ Yes __ No</p> <p>7) Stroke/ TIA.....__ Yes __ No</p> <p>8) Seizures.....__ Yes __ No</p> <p>9) Any underlying medical conditions: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List all surgeries you have had below:</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>4) _____</p> <p>5) _____</p>
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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 INFORMATION

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

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

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

Relationship to Patient

Print Name

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