FLEXIBLE SIGMOIDOSCOPY PREP

PATIENT: _____ DATE: _____

ARRIVAL TIME: _____ SUITE: _____

ATTENTION

If, after reading your pre-procedure information packet, you have **ANY** questions, please contact our staff at:

615-383-0165 (Dr. Mertz & Dr. Owings)

615-250-4108 (Dr. White)

If you have had a colon x-ray, please bring it with you.

PLEASE PLAN ON STAYING WITH US FROM 2-4 HOURS

For your test preparation you will need to obtain from any pharmacy the following non-prescription items:

Four (4) Senekot tablets
Two (2) enemas

Preparation

The afternoon before your test you should have a clear liquid supper. Take the four (4) Senekot tablets at bedtime the night before your test.

If your test is scheduled before noon, do not eat or drink anything after midnight the night before your test except a small amount of water to take your regular medications.

If your test is scheduled after noon, you may have clear liquids until 7:00am the day of your test. After 7:00am you should not have anything to drink except a small amount of water to take your regular medications.

One hour before leaving home, take two enemas rectally according to the following instructions: Take one enema, hold it in for three to five minutes, expel the fluid; immediately take the second enema by the same instructions.

Clear Liquid Examples

- Gatorade (NOT RED)
- Tea or water
- Soft drinks (Sprite, 7up)
- Juice (apple, white grape)
- Coffee (NO CREAM)
- Broth or bouillon
- Jello (NOT RED)
- Popsicles (NOT RED)

About Your Medications (Read at least 1 week before test)

- **Do Not Take** any Iron, Carafate or Sucralfate during your prep or the day of your exam.
- **If you take Blood thinners and/or vitamins: please see next page**
- **Asthma or COPD:** please bring your inhaler with you on the day of your procedure.
- **Take your blood pressure medications, seizure medications and/or inhalers** the morning of your procedure with enough sips of water to completely swallow them at least 2 hours prior to your arrival time
- **If you have Diabetes:**
    - **DO NOT TAKE** any diabetic oral agent the morning of your procedure.
    - Please bring your diabetic medication or insulin with you the day of your procedure
    - If you use an insulin pump, DO NOT turn it off; continue basal rate.
    - While you are on a liquid diet, you should only take **HALF** the dosage of your diabetic oral agent or insulin.
    - Check your blood sugar the morning of your procedure. **Do not take morning dose**. **After your procedure**, if you are eating, take your normal dose of insulin or other diabetic medication.

If you take blood thinning medication, herbal supplements or vitamins:

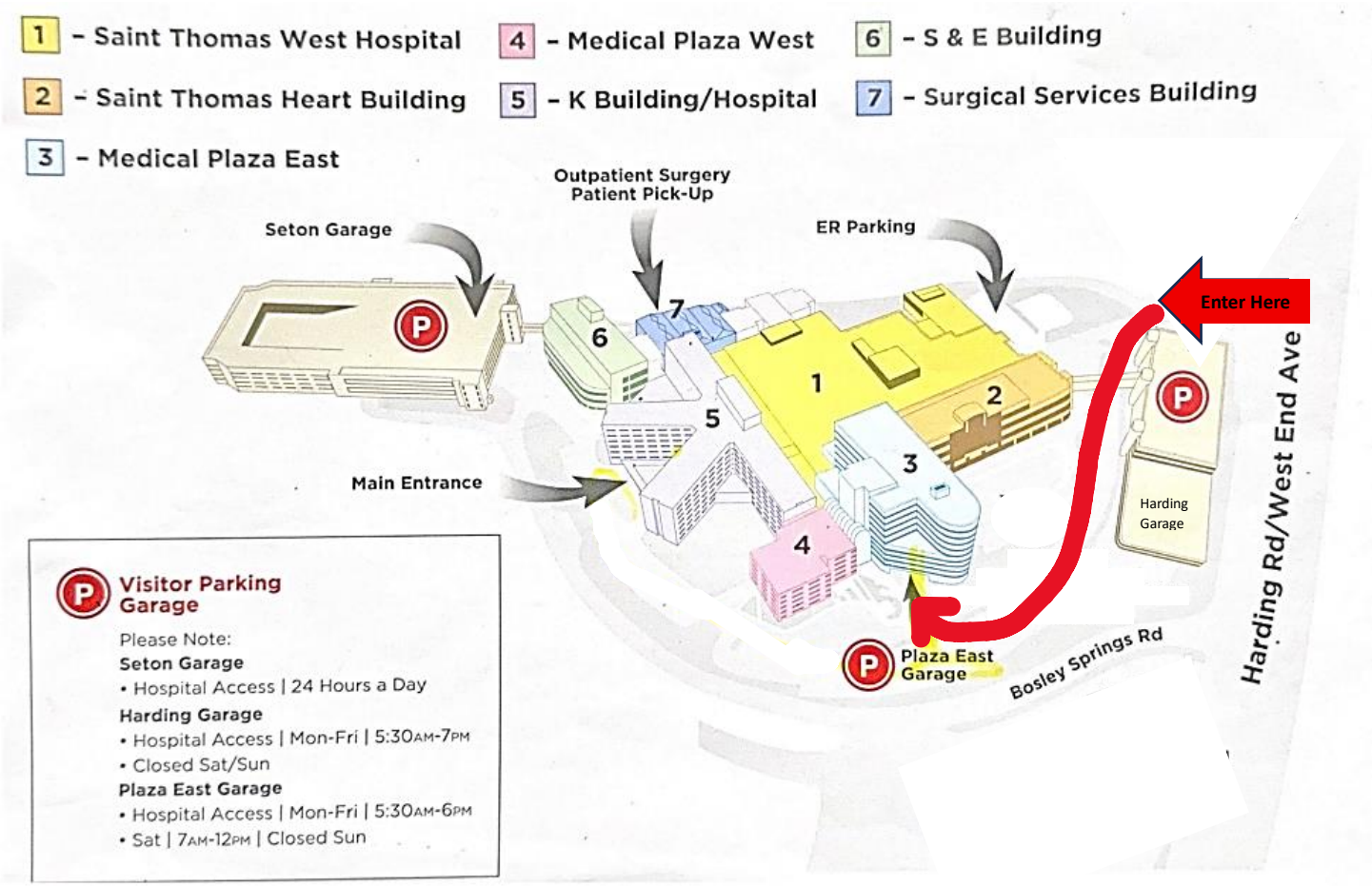
- Blood thinning medications must be stopped or adjusted per the needs of the individual patient. This adjustment **must** be approved by your prescribing physician prior to your procedure.

- If your prescribing physician does not approve of discontinuing your blood thinner, we can perform the procedure, but we may not take any biopsies, remove polyps or undertake any other therapeutic interventions during your procedure.

Stop or adjust your medications listed below

Medication	Adjustment required	Further Details/Instructions
Xarelto, Pradaxa, Eliquis, Brillinta	Stop 2 days prior to procedure	Unless prescribing physician instructs NOT to stop
Effient, Plavix	Stop 7 days prior to procedure	Unless prescribing physician instructs NOT to stop
Coumadin (Warfarin)	Stop 5 days prior to procedure	Unless prescribing physician instructs NOT to stop
Aspirin (any medication containing aspirin)	Stop 7 days prior to procedure	Unless prescribing physician instructs NOT to stop
Stop supplements: Herbal, vitamins, and fish oil	Stop 5 days prior to procedure	
Ozempic, Mounjaro, Trulicity, Victoza, Rybelsus, Wegovy, or other GLP-1 agonist	Stop 7 days prior to procedure	

THE ENDOSCOPY CENTER OF ST. THOMAS



We are located in St. Thomas Medical Plaza

4230 Harding Pike, Nashville TN 37205

PARKING:

- Park in Medical Plaza East parking garage and take elevators to your designated floor (Third floor for suite 309 or fourth floor for suite 400).

- You may also park in Valet which is located by the Medical Plaza West parking garage. **(Valet is Open 7am-5pm)**

Patient Medication List

Patient's Name: _____ DOB: _____

Pharmacy:_____ Pharmacy Phone: _____ Pharm. Address: _____

Reviewed by RN:_____

Drug Allergy	Reaction		Drug Allergy	Reaction

Please list all medications: Including aspirin, blood thinners, herbs, vitamins, supplements, etc. below

Medication	Dose	Frequency	Last Dose	AFTER DISCHARGE (office use) Continue	Stop	Instructions

Patient Signature: _____ Date: _____

AFTER DISCHARGE

NEW medications or changes to existing medications below **OR** NO changes this visit _____

Medication	Dose	Frequency	Special Instructions

Date:_____

Nurse Signature: _____ Physician Signature: _____

Patient History Form

Patient Name: _____ DOB: _____
Age:_____ Height:_____ Weight:_____

Race: White/Caucasian / Black-African American / Hispanic / Other: _____
Ethnicity: Non-Hispanic- Latino / Hispanic-Latino / Declines to provide information: _____
Preferred Language: English / Spanish / Other: _____

Have you had this procedure before? _____ Yes ____No By Whom? _____
What are your symptoms? _____ How long? _____

Primary Care Doctor: _____ Phone: _____
Referring Doctor: _____ Phone: _____

General	Yes	No	**Cardiovascular**	Yes	No	**Gastrointestinal**	Yes	No	**Musculoskeletal**	Yes	No
Tiredness			Dizziness/fainting			Nausea			Muscle weakness		
Fever			Chest pain			Rectal bleeding			Implanted device		
Loss of Appetite			Irregular heart beat			Vomiting			**Dermatologic**	Yes	No
Weight Gain			Palpitations			GERD			Allergies		
Weight Loss			Swelling of ankles			Ulcers			Hives		
Hearing loss			Heart failure			Diverticulosis			Itching		
Head/Neck	Yes	No	High blood pressure			Crohn's			Yellowing of skin		
Glaucoma			Heart attack			Colitis			Rash		
Loss of vision			Heart stents			Hepatitis			Open sores		
Sinus Problems			Blood clots			Hemorrhoids			**Neurologic**	Yes	No
Endocrine	Yes	No	Pacemaker			Hiatal hernia			Seizures		
Diabetes			Defibrillator			Trouble swallowing			Stroke		
Thyroid Disorder			Coronary artery disease			**Genitourinary**	Yes	No	TIA		
Respiratory	Yes	No	Heart valve Disease			Dark urine			Neuropathy		
Asthma with frequent inhaler use			Peripheral Vascular Disease			Difficulty urinating			Migraines		
COPD/Emphysema			High Cholesterol			Recurrent UTI			Seizures		
Shortness of breath			**Gastrointestinal**	Yes	No	Blood in urine			Tremor		
Sleep Apnea			Abdominal swelling			Urinate frequently			Vertigo		
Use CPAP/BiPap			Anal/rectal pain			Dialysis			Fibromyalgia		
Home Oxygen use			Abdominal pain			Kidney failure			**Psychiatric**	Yes	No
Pneumonia			Change in bowel habits			Kidney Disease			Bipolar		
Hematology	Yes	No	Constipation			**Musculoskeletal**	Yes	No	Schizophrenia		
Blood thinners			Diarrhea			Chronic Pain			PTSD		
Blood disorder			Colostomy			Gout			Anxiety		
Anemia			Heartburn/ Reflux			Arthritis			Depression		
Bleed easily			Incontinence of stool			Back/Neck pain			Sleep Disturbances		
Female Patients:	Last menstrual cycle?					Any chance of pregnancy?			Type of Birth control:		

Please list all previous surgeries below

1.)	4.)	7.)
2.)	5.)	8.)
3.)	6.)	9.)

Please circle self/family members with any of the following medical history below

Colon Polyps	Self	Mother	Father	Sister	Brother	Daughter	Son
Crohn's Disease	Self	Mother	Father	Sister	Brother	Daughter	Son
Ulcerative Colitis	Self	Mother	Father	Sister	Brother	Daughter	Son
Liver Disease	Self	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	Self	Mother	Father	Sister	Brother	Daughter	Son
Biliary Cancer	Self	Mother	Father	Sister	Brother	Daughter	Son
Pancreatic Cancer	Self	Mother	Father	Sister	Brother	Daughter	Son
Other Cancer	Self	Mother	Father	Sister	Brother	Daughter	Son

Type of Cancer: _____

Any Other Medical Conditions You May have: _____

Social History

Do you drink alcohol Yes / No
How much:_____ *How often*:_____
Do you smoke/vape or chew tobacco? Yes / No
Amount per day? _____ *How Long?* _____
Have you smoked in the past?
Amount per day? _____ *How long?* _____
Do you do recreational drugs? Yes / No
What type? _____

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 and/or anesthesia 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, physician's office, anesthesia and/or pathology providers are 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. I am aware that I may receive a separate bill should there be any pathology performed from the pathology companies.

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 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

Parent/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.

Do you have an Advanced Directive for healthcare? Yes or No (circle) If No, would you like any information? Yes or No (circle)
Did the patient bring a copy to the Center? Yes or No (circle) If provided, a copy is placed in patient's medical record.

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 own 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 license 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 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 questions 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

NASHVILLE GASTROINTESTINAL SPECIALIST, INC.

Dr. Howard Mertz **Dr. Edward White** **Dr. Anna Owings**

FELLOWS OF AMERICAN COLLEGES
OF PHYSICANS & GASTROENTEROLOGY
DIPLOMATES OF A.B.L.M.
SUBSPECIALTY OF GASTROENTEROLOGY

By my signature below, I acknowledge I have received a copy of Nashville Gastrointestinal Specialist, Inc.'s Notice of Privacy Practices concerning my protected healthcare information.

_____ _____
Patient Name (Printed) Date

_____
Patient or Patient Representative Signature

I authorize the following individuals to receive information about my health status, which may include information about my protected healthcare information.

_____ _____
Print Name Relationship Phone Number

_____ _____
Print Name Relationship Phone Number

_____ _____
Print Name Relationship Phone Number

I authorize Nashville Gastrointestinal Specialist, Inc. will only release my protected healthcare information to the individuals that I have indicated on this form. All other requests for protected healthcare information must be made in accordance with the Nashville Gastrointestinal Specialist, Inc. HIPAA Policy and Procedures Manual concerning the privacy of my protected healthcare information.

_____ _____
Patient Name (Printed) Date

_____
Patient or Patient Representative Signature