GATEWAY
GASTROENTEROLOGY

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314.529.4900 || WWW.GATEWAYGI.COM

ENDOSCOPY PREPARATION INSTRUCTIONS

Please read this information as soon as you receive it!

If you have any questions about these instructions or to make a change to your appointment, Please call:

- Office: 314.529.4900 (option 2)
- Exchange: 314.388.6519

DATE AND TIME

Your procedure is scheduled for _____ at _____

Your procedure is scheduled at GATEWAY ENDOSCOPY CENTER. Please arrive 1 HOUR prior to your scheduled appointment time.

LOCATION

Gateway Endoscopy Center is located in the Walker Medical Building at 12855 North 40 Drive, Suite 150, St. Louis, MO 63141 in the South Tower.

For patients coming from the east (traveling west on U.S. 40):

- Exit U.S. 40 at Mason Road (Exit 24).
- Immediately upon exiting onto Mason Road, make a quick right onto N. 40 Drive (the frontage road).
- Go about 1/2 mile to the Walker Building and turn left into the parking lot. (The building is located between Lutheran Hour Ministries and CBC (Christian Brothers) High School.
- Enter the doors for the South Tower. Take the stairs or the elevator to the first floor. Suite 150 is on the right.

For patients coming from the west (traveling east on U.S. 40):

- Exit U.S. 40 at Mason Road (Exit 24)
- Go to the stoplight at Mason Road and make a left.
- Go across the bridge over U.S. 40 and immediately turn right on N. 40 Drive (the frontage road).
- Go about 1/2 mile to the Walker Building and turn left into the parking lot. (The building is located between Lutheran Hour Ministries and CBC (Christian Brothers) High School.
- Enter the doors for the South Tower. Take the stairs or the elevator to the first floor. Suite 150 is on the right.

If you cannot keep your scheduled appointment, please notify us at least 2 business days before your scheduled time.

Please review the "special circumstances" section of this document carefully to see if you require special instructions or modifications.

PREPARATION:

- **Nothing to eat or drink after midnight.**
- You may take your usual medications with sips of water **as early as possible on the day of the procedure**.

The day of the procedure:

- Arrive at Gateway Endoscopy Center **1 hour prior** to your scheduled appointment time.
- **You will need someone to drive you to and from the Endoscopy Center AND wait in the waiting room until the procedure is done. The procedure can't be done unless you have a driver. You will be there for approximately 2 hours from the time you arrive.**
- We have enclosed a patient information form, a medical history form, medication list and a financial policy. **Please fill these out at home and bring them with you to your appointment along with insurance cards and drivers license.** If you have any questions, the nurse will go over it with you at the time of your appointment.
- All Female Patients: If you are between the ages of 12-49, you will be required to give a urine specimen unless you have had a Hysterectomy or Tubal Ligation.

SPECIAL INSTRUCTIONS:

Patients with an automatic implantable defibrillator and /or pacemaker: Please call us at least five (5) days before the procedure for instructions.

Coumadin (warfarin): Call your primary care doctor or cardiologist and ask if you can safely stop the Coumadin four (4) days before your procedure. If your doctor tells you that you cannot stop the Coumadin, then please call us immediately to make us aware of this. We will then discuss with you the various options available.

If you take **Eliquis (apixaban), or Pradaxa (dabigatran):** Call your primary care doctor or cardiologist and ask if you can safely stop these medications 48 hours before your procedure. If your doctor tells you that you cannot stop these medications, please call us immediately to make us aware of this. We will then discuss with you the various options available.

If you take **Xarelto (rivaroxaban), Aristra (fondaparinux), Fragmin (dalteparin), Iprivask (desirudin), or Lovenox (enoxaparin):** Call your primary care doctor or cardiologist and ask if you can safely stop these medications 24 hours before your procedure. If your doctor tells you that you cannot stop these medications, please call us immediately to make us aware of this. We will then discuss with you the various options available.

Iron: Stop iron four (4) days before the procedure. Iron can make preparation difficult and result in a poorly cleaned colon.

Antibiotics for procedures: Recent publications from both the American Heart Association and American Society for Gastrointestional Endoscopy state that antibiotics are not necessary for routine endoscopic procedures.

Insulin: Call your primary care doctor at least five (5) days before the procedure and ask for instructions.

Plavix: (clopidogrel) and aspirin: It is not necessary to stop Plavix and aspirin prior to your procedure.

Herbal Medications: It is best to stop any herbal remedies five (5) days before the procedure as many of them can thin the blood and increase the risk of bleeding during the procedure.

ADDITIONAL INFORMATION:

Approximately 3 business days prior to your procedure, you will be receiving an automated phone call from our Phone Tree system reminding you of your appointment. Please listen to this entire message and press the appropriate number for your response regarding your appointment. If you are not at home, Phone Tree will leave a message on your answering machine. Unless you want to cancel or reschedule your appointment, it is not necessary to call the office to confirm. We will assume you are keeping your scheduled appointment unless we hear from you.

You may visit our website (www.gatewaygi.com) for more detailed information regarding the physician you will be seeing and other services offered.

HOW DID YOU HEAR ABOUT OUR PRACTICE? ☐ Primary Care M.D. ☐ OB/GYN ☐ Internet ☐ Friend/Family ☐ Advertisement ☐ Other

Name: Mr/Mrs/Ms.

Address:

City: State: Zip Code:

Social Security Number: Date of Birth:

Home Phone Number: Alt. Contact Number:

Employer: Occupation:

Marital Status Spouse's Name:

In Case of Emergency Contact: Relationship of Emergency Contact:

Emergency Contact Number: Referring Physician:

Email Address:

The following is REQUIRED by the State of Missouri (select one): ☐ Hispanic or Latino ☐ Neither Hispanic nor Latino

RACE: ☐ White ☐ Black or African American ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ Other not listed ☐ Multi-Racial (two or more races) ☐ Choose not to answer

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: Phone Number:

Policy/Id Number: Group Number:

Relationship to policy holder: Policy Holder DOB:

Secondary Insurance Company: Phone Number:

Policy/Id Number: Group Number:

Relationship to policy holder: Policy Holder DOB:

POLICY HOLDER

Name: Mr/Mrs/Ms.

Address:

City: State: Zip Code:

Social Security Number: Date of Birth:

Home Phone Number: Alt. Contact Number:

Employer: Occupation:

Responsible party/Guarantor's Signature:

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

By providing the information I agree that Gateway Gastroenterology, Inc and Gateway Endoscopy Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, leave a voice message on an answering device, send mail to my home address, or email notification regarding my care, our services, or my financial obligation. I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to Gateway Gastroenterology, Inc and Gateway Endoscopy Center for services rendered. I permit a copy of this authorization to be in place of the original. I understand that I am financially responsible to these providers of service for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required. I have received a copy of Notice of Privacy Practices.

Signature

Date

MEDICATION RECONCILIATION FORM

Patient Name: _____

Date: _____

ALLERGIES (food, medication, latex, etc)

Medication Name	Reaction	Medication Name	Reaction

- List **ALL YOUR MEDICATIONS** including **eye drops, over-the-counter**, and **alternative medicines** such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety that you provide complete and accurate information.
- Please let your nurse know if you do not remember all of the medications that you take.

MEDICATION LIST

Medication Name	Dose	How often do you take it?	Why are you taking this medication?	Last Dose Taken

It is suggested that you provide a copy of this list to your Primary Car Provider.

OFFICE USE ONLY

Reviewed by RN: _____

Signature Date/Time

☐ No Changes to Medications

☐ Changes

New Medication Name	Dose	Frequency	Purpose of Medication

☐ Patient education regarding medication changes

Medication Reconciled by RN: _____

Signature Date/Time

Gateway Endoscopy Center and its providers are not responsible for medications ordered by other organizations or providers.

PATIENT HISTORY FORM

Name: D.O.B. Referred By:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Retired Occupation Number of Children:

Driver's Name: Driver's Phone Number

CURRENT SYMPTOMS

- ☐ Difficulty Swallowing
- ☐ Heartburn/Indigestion
- ☐ Sore Throat
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Gas/Bloating
- ☐ Abdominal Pain
- ☐ Recent Weight Change
- ☐ Change in Bowel Movements
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding

PERSONAL MEDICAL HISTORY

- ☐ GERD
- ☐ Barrett's Esophagus
- ☐ Schatzki's Ring
- ☐ Hiatal Hernia
- ☐ Esophageal Cancer
- ☐ Stomach Cancer
- ☐ Ulcers
- ☐ Celiac Sprue
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Colon Polyps/Colon Cancer
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Heart Disease/ Stents
- ☐ CHF
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Asthma
- ☐ COPD
- ☐ Anemia
- ☐ Seizures
- ☐ Migraines
- ☐ Sleep Apnea
- ☐ Hearing Loss

Cancer

SMOKING

☐ Yes ☐ No

Pk/Yrs: Yr Quit:

ALCOHOL

☐ Yes ☐ No

Drinks/day: Yr Quit:

FAMILY HISTORY OF COLON CANCER?

☐ Yes If yes, who?

☐ No

LAST COLONOSCOPY

Year? > 3 Years

FAMILY HISTORY OF POLYPS?

☐ Yes If yes, who?

☐ No

LAST UPPER ENDOSCOPY

Year?

SURGERIES

Do you have pain now or have you had pain in the last several weeks?

☐ Yes ☐ No If yes, rate level of pain on a scale of 1-10 with 10 being the worst:

Describe the pain: Where is it located?

What aggravates it? How long does it last?

Prior Problems with anesthesia?

☐ Yes ☐ No If yes please describe:

Do you have any physical, psychological, or emotional needs?

Are you able to perform activities of daily living without assistance? ☐ Yes ☐ No

REASON FOR PROCEDURE

Patient's Signature: Date:

Nurse's Signature: Date:

FINANCIAL DISCLOSURE

For billing purposes, there are separate service components for which you will be billed separately:

1. PHYSICIAN'S PROFESSIONAL CHARGE. Your physician will bill this charge separately to you. This billing is for the physician's professional services that are provided during your procedure.
2. FACILITY CHARGE. We will bill a facility fee based on the type and number of procedures being performed at Gateway Endoscopy Center (GEC).
3. LABORATORY AND PATHOLOGY CHARGE. If you have a biopsy done or polyp(s) removed, you will receive a bill from the laboratory that processes your pathology.
4. ANESTHESIA CHARGE. If your procedure utilizes the services of the anesthesia provider, this professional charge will be billed separately to you.

Payments made to the center on the day of service are credited towards the facility charge only.

I agree to pay GEC in accordance with its negotiated rates and terms which are 30 days from date of invoice. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection including but not limited to attorney fees, court costs and filing fees.

I authorize direct payment to GEC of any insurance benefits. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

If you do not have insurance, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. To assist you, we accept checks, MasterCard, Visa, Discover, American Express and Care Credit.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signed: _____ Date: _____

Witness: _____

INFORMATION RELEASE

I _____ give consent for any medical information to be released to the following parties:

(Print Patient's Name Here)

INFORMATION TO BE RELEASED TO THE FOLLOWING PARTIES:

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

It is the patient's responsibility to contact this office if any name listed above would need to be removed. A new consent form would need to be filled out.

_____

Patient Signature DOB Date

_____

Witness

NOTICE

Anyone having concerns about the quality of care provided in this organization may report these concerns to the organization's management, the Missouri Department of Health and Senior Services, the Joint Commission or Medicare. A quality Incident Report Form is available upon request. You may choose to report anonymously or provide your name and contact information.

The Joint Commission
JCAHO
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
(800) 994-6610

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Contact the Health Facilities Regulation Unit P.O. Box 570
Jefferson City, MO 65102
(573) 751-6303
dhcc.mo.gov
You may also fill out a concern form online at
http://www.dhss.mo.gov/AskUs.html

MEDICARE

Website for the office of the Medicare Beneficiary Ombudsman
http://www.cms.hhs.gov/ombudsman/resources.asp
(800) 633-4227

SIGNATURE
MEDICAL GROUP
PHYSICIANS MAKING A DIFFERENCE

SIGNATURE MEDICAL GROUP, INC.

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Description of relationship to the patient

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual/Representative refused to sign the form
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____