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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 _____

A nurse from St. Luke's will be contacting you the Friday before your test with the exact arrival time for your procedure on Monday.

Location

Your procedure is scheduled at **St. Luke's Endoscopy Center**. St. Luke's Endoscopy Center is located in the WingHaven Medical Building at 5551 WingHaven Blvd., Ste. 40, O'Fallon, MO 63368.

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

- Exit U.S. 40 at WingHaven Blvd.
- Turn right onto WingHaven Blvd.
- Go to 2nd stoplight and make a left turn into the parking lot of St. Luke's WingHaven Medical Building.
- The Endoscopy Lab is located in Suite 40.

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

- Exit U.S. 40 at WingHaven Blvd.
- Turn left on WingHaven Blvd.
- Go across the bridge over U.S. 40 and go to the 3rd stoplight. Make a left turn into the parking lot of St. Luke's WingHaven Medical Building.
- The Endoscopy Lab is located in Suite 40.

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.**
- ▶ **IF** your procedure is scheduled for **at or after 2:30 pm**, you may **consume clear liquids only before 7 am** the morning of your procedure.
- ▶ 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 St. Luke's Endoscopy Center at WingHaven Medical Building **at the time the given by the nurse calling you on the Friday before your procedure.**
- ▶ **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 to 2-1/2 hours from the time you arrive.**
- ▶ We have enclosed a patient information form and a medication list. **Please fill these out at home and bring them with you to your appointment along with your 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, Jantoven (warafin): 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.

Antibiotics for procedures: Recent publications from both the American Heart Association and American Society for Gastrointestinal 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 will also receive a call from St. Luke's GI/Endoscopy Lab a couple days prior to your appointment to go over your health history.

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.

STREET ADDRESS:

CITY:

STATE:

ZIP:

SSN:

DOB:

HOME PHONE NUMBER:

ALTERNATE NUMBER:

EMPLOYER:

OCCUPATION:

MARITAL STATUS:

SPOUSES NAME:

EMERGENCY CONTACT:

RELATIONSHIP TO CONTACT:

THE FOLLOWING IS REQUIRED BY THE STATE OF MISSOURI:

☐ Hispanic or Latino ☐ Neither Hispanic or Latino

RACE:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Island
☐ Other ☐ Multi-Racial (two or more races) ☐ Choose Not to Answer

MEDICAL INSURANCE INFORMATION

Primary Insurance Company

Phone Number

Policy/Id#

Group#

Relationship to policy holder

Policy Holder DOB

Secondary Insurance Company

Phone Number

Policy/Id#

Group#

Relationship to policy holder

Policy Holder DOB

Responsible Party

NAME: MR./MRS./MS.

STREET ADDRESS:

CITY:

STATE:

ZIP:

SSN:

DOB:

HOME PHONE NUMBER:

ALTERNATE NUMBER:

EMPLOYER:

OCCUPATION:

RESPONSIBLE PARTY/GUARANTOR'S SIGNATURE

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

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 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 Gateway Gastroenterology, Inc.'s Notice of Privacy Practices

SIGNATURE

DATE

SIGNATURE

DATE

GATEWAY GASTROENTEROLOGY, INC. MEDICATION SHEET

For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below and bring it with you at the time of your appointment. Thank You!

Date _____

Medication Allergies and Reactions

	Medication (Include non-prescription and herbal supplements)	Dosage	Frequency (how often)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

*If more space is needed, please continue on the back of this form.

Signature/Title/Date of RN Reviewing Medication List

FINANCIAL DISCLOSURE

Dear Patient:

We would like to take this opportunity to welcome you, and to let you know that we are committed to providing you with the best possible care. Please take a few minutes to read this important information regarding our financial policies. We will gladly discuss your proposed treatment and answer any questions you have relating to your charges:

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

1. **Physician Professional Charge:** We will bill this charge for you. This billing is for the physician's professional services that are provided during your procedure. **If you are a new patient to our office there will be a separate consultation fee.**
2. **Facility Charge:** There will also be a facility bill for the use of the facility in which your procedure is being performed. If the procedure requires additional services the billing will be increased depending on the added requirement. The facility will bill these charges separately to you.
3. **Laboratory and Pathology Charge:** If you have a biopsy taken, you will receive a bill from the laboratory that processes your biopsy.
4. **Anesthesia Charge:** If your procedure utilizes the services of the anesthesia provider, this professional charge will be billed separately to you. This billing is for the anesthesia provider's professional services that are provided during your procedure.

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

If you have insurance, we will file a claim for you. Please understand that your insurance is a contract between you and your insurance company and that complete payment to us is ultimately your responsibility. Under certain circumstances some insurance carriers may not always cover or may deny payment for services provided. Our office will bill your insurance first. After your insurance processes the claim, we will forward a statement to you if there is any patient responsibility. Please remit payment in a timely fashion or call the office to make payment arrangements.

If you belong to an insurance plan, we will follow guidelines set forth in those plans. Please be sure to contact your primary care physician if your insurance requires a referral. Services cannot be rendered if proper authorization has not been given. We **DO** participate in Medicare.

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, and Discover.

We recognize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. We are willing to work with you, but we need you to communicate with us. We do use outside agencies as a means of collections should we deem it necessary.

If you have questions about the above information or any uncertainty regarding insurance coverage, don't hesitate to ask us. We are here to help you. You can reach our billing department at 314-529-4990.

INFORMATION RELEASE

I _____ GIVE CONSENT FOR ANY MEDICAL
(Print Patient's Name Here)

INFORMATION TO BE RELEASED TO THE FOLLOWING PARTIES:

_____ 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 D.O.B

DATE

WITNESS



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)

