GATEWAY
GASTROENTEROLOGY
Office: (314) 432-5900
www.gatewaygi.com

David D. Benage, M.D.
Jeffrey T. Kreikemeier, M.D.
Loren H. Marshall, M.D.
Jeffrey E. Mathews, M.D.
Brian C. McMorrow, M.D.
Richard T. Riegel, M.D.
Andrew Y. Su, M.D.
Fred H. Williams, M.D.
Cheri M. Carmody, A.N.P.

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**: 314.432.5900 - 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.		
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 ENDOSCOPY CENTER - MEDICATION RECONCILIATION FORM

Allergies (food, medication, latex, etc)
Name and Type of 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 Care Provider.

Reviewed by RN:_____
Signature Date/Time

__ No Changes to Medications
__ Changes
__ Patient education regarding medication changes

Medications 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

Patient Name_____ Date of Birth: _____ Referred by _____
Driver _____ Driver's Phone Number _____

Married Divorced Single Separated Widowed
Retired Occupation _____ Number of Children _____

Medical History (Please Circle):

Rectal Bleeding	Heartburn	Difficulty Swallowing	Hiatal Hernia
Diverticulosis/Diverticulitis		Gas/Bloating	Constipation
Diarrhea	Gallbladder Problems	Pancreatitis	Loss of Appetite
Change in bowel movements		Nausea/Vomiting	Abdominal Pain
Crohn's	History of Ulcers	History of Polyps	History of Colon Cancer
Kidney Problems	Indigestion	Recent Weight Change	Sore Throat
Liver Disease	Shortness of Breath	Asthma	High Blood Pressure
Seizures	Stroke	Migraines	Ulcerative Colitis
Diabetes	Heart Disease/Stents	CHF	Anemia
Dentures	Hearing Loss	COPD	Sleep Apnea
Glasses/Contacts			

Other _____

Surgeries _____
_____

Smoking Y/N Pack/Years _____ Year Quit _____
Alcohol Y/N Drinks/Day _____ Year Quit _____

Family History of Colon Cancer? Y/N If yes, who? _____
Family History of Polyps? Y/N If yes, who? _____

Last Colonoscopy - Year? _____ Last Upper Endoscopy - Year? _____

Do you have pain now or have you had pain the last several weeks? Y/N
If yes, rate the pain on a scale of 1-10, with 10 being the worst _____
Describe the pain. Where is it located? What aggravates it? What alleviates it? How long does it last?
_____
_____
_____

Prior problems with anesthesia? Y/N
If yes, please describe _____

Reason for Procedure: _____

_____ _____
PATIENT SIGNATURE NURSE SIGNATURE INDICATING REVIEW

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 and 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

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