



Office: (314) 529-4900
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.

Flexible Sigmoidoscopy 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 you 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 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.

Bowel Preparation:

Necessary items:

- One bottle of Magnesium Citrate
- Two 5 mg. Dulcolax pills. Dulcolax is available over the counter. Please purchase the laxative formula not the stool softener.
- One Fleets enema (Do NOT use mineral oil based enema).

The day before your test:

- Your diet should consist of only liquids after lunch on the day prior to your test. You should have **NO SOLID FOODS!!** Examples of clear liquids include: water, any kind of soda, Gatorade, coffee, Popsicles, unsweetened tea, Jell-O, broth, bouillon, and fruit juices that you can see through (apple and grape are OK, orange and tomato are not). You may have all the clear liquids you desire throughout this day and evening. No alcohol allowed. Please note that if you consume red Jell-O, Gatorade or popsicles with your bowel prep that your stool may be red in color. This is nothing to be alarmed about.
- Prior to your evening liquid meal, take one bottle of Magnesium Citrate.
- With that evening meal, take 2 Dulcolax pills.
- You may take your usual medications as prescribed by your physician.

The day of your procedure:

- Once again, you may have a clear liquid diet up until the time of your examination.
- Approximately one-half hour before you leave to come in for your flexible sigmoidoscopy, please give yourself one Fleets enema. Attempt to hold this enema in as long as possible.
- Arrive at St. Luke's Endoscopy Center at WingHaven Medical Building **1 hour prior** to your scheduled appointment time.
- Please bring a driver with you because if you elect to have your procedure with anesthesia, you will not be able to drive home.
- 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.

If you have any questions, please call our office at 314-432-5900 and press Option #2 for the appointment line.

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)

