Carolinas Gastroenterology Centers

Ballantyne Location
15110 John J. Delaney Drive, Suite 120
Charlotte, NC 28277
704-512-2140

Medical Center Plaza Location
1001 Blythe Boulevard, Suite 400
Charlotte, NC 28203
704-355-4178

We are pleased that you and your physician have chosen Carolinas Gastroenterology Center for your upcoming procedure. Our staff is professionally trained to provide the highest quality care at the lowest possible cost. We want your visit to be an excellent experience. It is the responsibility of the Center to provide you with a written copy of your rights and responsibilities as well as the Center's policy on Advance Directives. We encourage you to ask questions and to let the staff know of any special needs you may have.

Advance Directives:
Each patient has the right to be treated in an individual and holistic manner. The issues of a Living Will, Advance Directive and Healthcare Power of Attorney will be addressed according to each patient's desire and the need for more information.

- To ensure that all necessary actions are taken to preserve life in an emergency situation, all Advance Directives orders will be limited and we would attempt to resuscitate and transfer to a hospital in the event of deterioration while you are a patient. If you so desire, a copy of your Advance Directive may be made a part of your medical record. In the event that you require transfer to another facility, this information will be transferred along with any other necessary medical information.

Every patient has the right to cancel their appointment if they are not satisfied with the statement above and reschedule with another provider of choice.

To Report Complaints:
Sharing concerns, complaints and grievances will not compromise a patient's care and/or treatment of services. If you have a question about your care or the safety of your surroundings, please let us know.
If at any time you have a complaint or concern, you may contact your nurse, the nursing supervisor or you may call Carolinas Gastroenterology Center Administrator at 704-512-2140 or call the Customer Care Line at 704-355-8363. Although it is our desire to resolve your concerns at the local level, it is your right to make a complaint directly to the NC Department of Health and Human Services (State Survey Agency) and the Accreditation Association for Ambulatory Health Care is as follows:

Please read the attached patient rights and responsibilities and complete any paperwork included with your packet. If you have any further questions contact our office at your scheduled facility location.

Carolinas Gastroenterology Centers-MCP and Ballantyne
Patient Rights

The patient will be accorded impartial access to available medical treatment regardless of race, creed, national origin, religion, sex, age or handicap. The patient will have access to the interpreter when necessary and possible. The patient is also entitled to information regarding his/her rights at the earliest possible time in the course of his/her treatment. Each patient will receive information regarding his/her rights and responsibilities at the earliest possible time in the course of their care. The patient is entitled to information about Center rules and regulations affecting patient care and conduct. The patient has the right to cancel their appointment if they are not satisfied and reschedule with another provider of choice. Patients are entitled to information about each facility's mechanism for the initiation, review, and resolution of patient complaints.

Sharing concerns, complaints and grievances will not compromise a patient's care, treatment or services. If you have a question about your care or the safety of your surroundings, please let us know.

> If at any time you have a complaint or concern, you may contact your nurse, the nursing supervisor or you may call the Administrator at 704-512-2140 or call the Customer Care Line at 704-355-8363. Although it is our desire to resolve your concerns at the local level, it is your right to make a complaint directly to the NC Department of Health and Human Services (State Survey Agency) and the Accreditation Association for Ambulatory Health Care is as follows:

Division of Health Service Regulations
Acute and Home Care Branch
2711 Mail Service Center, Raleigh, NC 27699-2711
Branch Manager: Rita Horton
1-800-624-3004 (Toll-free)
Web site: www.facility-services.state.nc.us
Visit the Ombudsman's webpage at:
www.cms.hhs.gov/center/ombudsman.asp

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Tel: 847/853.6060
Fax: 847/853.9028
Email: info@aaahc.org

> If the patient issues are not satisfactorily addressed while at Carolinas Gastroenterology Centers, the investigation will continue. The intent is to provide the patient a letter outlining the findings within seven days.

The patient has the right to be free from restraints of any form that are not medically necessary.

The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

The patient has the right to quality care by competent individuals and high professional standards. The patient will also receive considerate, respectful care in a safe environment, which recognizes his/her personal dignity at all times and under all circumstances.

The patient has the right to be free from all forms of abuse, neglect, or harassment whether from staff, other patients, or visitors.
The patient is entitled to confidential treatment of his/her medical record. Copies of the patient's medical record will not be released without his/her prior authorization, except as needed due to transfer to another healthcare facility or as required by law or third party contract. The patient is entitled to timely access to his/her medical record except under limited circumstances which will be documented in the medical record.
The patient is entitled to privacy in treatment and in caring for personal needs to the extent possible with consideration, respect and full recognition of his/her dignity and individuality. He/She is also entitled to care that avoids unnecessary pain, discomfort and duplication. Patients have the right to appropriate assessment and management of pain.

The patient has the right to be free from seclusion and restraints and to the extent possible and in accordance with policy.

The patient is entitled to know who is responsible for providing his/her direct care, to receive information concerning his/her continuing healthcare needs, and alternatives for meeting those needs and to be involved in his/her discharge planning, the patient is entitle to receive, upon discharge, information regarding his/her continuing care needs and the means for meeting them.

The patient has the right to have advance medical directives (such as a living will, and/or healthcare power of attorney) concerning treatment or designating a surrogate decision maker with the expectation that the Center will honor the intent of the directive to the extent permitted by law and policy. The patient or surrogate decision maker is entitled to be involved in every aspect of the patient's care at the end of his/her life.

The center's policy for limiting advance directives is we would always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration. For information about Advanced Directives call 919-807-2167 or Visit www.NClifelinks.org

The patient is entitled to refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.

The patient has the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic patient care options when care is no longer appropriate or when transfer to another facility is necessary. Emergency procedures will be implemented without delay.

The patient and/or family member as designated by the patient have the right to participate in decisions involving his/her health care. Except in an emergency, the patient shall not be subject to any treatment, procedure, research, or donor programs without his/her voluntary, competent and understanding consent or the consent of his/her legally authorized representative.

The patient is entitled to request and receive an itemized and detailed explanation of his/her total bill for service rendered. The patient is also entitled to information and counseling on the availability to know financial resources for his/her healthcare.

The patient has the right to express his/her values and beliefs within the limits of the Center's mission and philosophy. Patients are allowed to exercise cultural, psychosocial, and spiritual beliefs that do not interfere with the well being of others, specific Center policy or the planned course of medical therapy for the patient.

The patient has the right to access protective services. The patient's guardian, next of kin or legally authorized, responsible person may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if:

1. the patient has been adjudicated incompetent in accordance with law,
2. is found by his/her physician to be medically incapable of understanding the proposed treatment or procedure,
3. is unable to communicate his/her wishes regarding treatment or
4. is an unemancipated minor.

Carolinas Gastroenterology Center

The patient is responsible for providing, to the best of his/her knowledge, a complete and accurate medical history, including to the extent possible, information about past illnesses, medications, including over-the-counter products and dietary supplements and any allergies or sensitivities, hospitalizations, family history of illness, and other matters relating to present health.

The patient is responsible for ex-pressing his /her concerns clearly and honestly to their physicians.

The patient is responsible for following the treatment plan recommended by his/her physician.
This may include following reasonable instructions of nurses and other Carolinas HealthCare System personnel as they implement the physician's plan of care and as they enforce applicable facility rules and regulations. The patient is responsible for disclosing whether previously agreed upon treatments are being followed and to indicate when he/she would like to reconsider the treatment plan.

- The patient is required to provide a responsible adult to transport him/her home from the facility and stay at the facility during the procedure.
    - The responsible adult is required to stay with the patient for 24 hours if required by his/her provider.
- The patient is responsible for requesting information and clarification about his/her health status or treatment when he/she does not fully understand what has been described.
- The patient is responsible to inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care.
- The patient is responsible for being considerate of the rights of others and all healthcare providers.
- The patient is responsible for his/her actions, and their consequences, if he/she refuses treatment or does not follow the physician's instructions.
- The patient is responsible for refraining from behavior that places the health of others at risk.
- The patient is responsible for providing the facility with accurate and timely information concerning his/her source of payment and accepts personal financial responsibility for any charges not covered by his/her insurance.
- The patient is responsible for asking questions. You and your family are responsible for asking questions when you do not understand your care or what you are expected to do. Let your doctor or nurse know about any pain you may experience.
- The patient and his/her family are responsible to promptly meet any financial obligation agreed upon with the facility.

Propofol Administration
ATTENTION

You will automatically be receiving **PROPOFOL** (deep sedation) for your procedure. It is **REQUIRED** by the anesthesiologist that someone accompany you to your appointment, stay with you throughout your procedure and take you home.

Advantages of Propofol sedation are:

- Minimal to no awareness of the procedure.
- Post-procedure recovery will be approximately 30 minutes.
- Most will not be nauseated.
- Most will return to eating quickly.
- Most will be able to transfer from car to home easily.
- Rapid transition from post-procedure period to normal daily functioning.

PROPOFOL will be administered by an anesthesiologist from American Anesthesiology 704-377-5772. Their charges will be processed through your insurance along with those from your physician's office, Carolinas Pathology and Carolinas Gastroenterology Center.

An alternate sedation such as DEMEROL/VERSED OR FENTANYL/VERSED is available upon request. This sedation is typically administered by a nurse assisting the gastroenterologist. **PLEASE NOTE THIS SEDATION WILL BE GIVEN ON A CASE BY CASE BASIS.**

IMPORTANT BILLING INFORMATION

- Although we will obtain prior authorization for your procedure, we ask that you contact your insurance company to verify exactly what is covered under your policy. This allows you, as a patient, to be aware of any out-of-pocket expenses you may incur.
- **The CPT code for a screening colonoscopy is 45378**. Routine/screening procedures may change to diagnostic procedures if biopsies are taken and/or polyps are removed.
- **The CPT code for an EGD may be 43235, 43239, or 43249**.
- If you are having a diagnostic procedure, you will need to know what your diagnostic benefits are.
- If you are receiving anesthesia (**PROPOFOL**) ask your insurance if this will be covered. **The billing code is 00810.**
- The doctor's office and surgical center **must** be notified of any changes in insurance plans as your insurance may require pre-authorization to be a covered benefit. Please be aware, **YOUR FINANCIAL RESPONSIBILITY MAY BE GREATER THAN YOUR REGULAR CO-PAY AT THE DOCTOR'S OFFICE.**

Please feel free to contact our office with any further questions regarding your procedure.

704-512-2140

CAROLINAS GASTROENTEROLOGY CENTERS

PATIENT INFORMATION - NAME: _____ D.O.B. __/__/____

Who is driving you home today? _____ **Phone number?** _____

An individual other than yourself is required to stay at the facility during the procedure. It is recommended that someone stays with you for the 24 hours following your procedure.

Is it OK for the doctor to **discuss the findings** with the person that is here with you? ❑YES ❑ NO

Why are you having a *colonoscopy*? ❑Bleeding ❑History of CA or polyps ❑No problems- 1st time screening

Why are you having an *EGD*? ❑Difficulty swallowing ❑Heartburn/Reflux ❑Barretts ❑Anemia ❑Black tarry stools

Current **Height**: _____ Current **Weight**: _____ (needed to give you the correct amount of medicine)

Date and Time you last drank ANY liquids: ____/____/____ _____

Date and Time you last ate solid food that you could chew (jello counts as liquid): ____/____/____ _____

Which prep did you take? ❑ NONE Check all that apply: ❑ Colyte ❑ Halflytely ❑ Nulytely ❑ Trilytely ❑ Enemas ❑ Magnesium Citrate ❑ Bisacodyl tabs (Dulcolax) ❑ MiraLAX ❑ Movi-Prep ❑ Suprep

Were you able to complete the colon cleansing prep?❑Yes ❑No ❑ N/A **If not, did you call the doctor?** ❑Yes ❑ No

Final Results of the prep: ❑ Liquid (colored water) ❑ Liquid with some stool ❑ Soft stool ❑ Solid stool

Please check the box for all that apply to you: ❑ **NONE OF THE BELOW APPLY TO ME**

❑ Current Cold / Upper Respiratory Infection ❑ Fever ❑ Reaction to Contrast Dye ❑ Hiatal Hernia

❑ History of Airway Difficulty ❑ Anesthesia Problems ❑ Other Sedation Problems

❑ Artificial Hips & or Knees (❑Right ❑Left) ❑ Heart Valve Replacement ❑ Pacemaker ❑ Defibrillator

❑ Removable teeth (partial plate, full denture, loose teeth, temporary crowns, etc.)

Enclosed in your packet, you will find the "Medicine Reconciliation Form". This has been provided to improve communication and medicine safety between you, your family and your healthcare providers. Please fill it out at home, to include dosages and when you took it last. Check your medication labels for spelling and doses. Bring the completed form with you to your Endoscopy procedure appointment. The Medication Form is a permanent part of your medical record.

Do you *usually* take any of the following? (Check all that you have ever taken)

❑ I **never take** ANY of the medicines below

❑ Aspirin ❑ Motrin, Advil, Ibuprofen ❑ Naprosyn, Aleve ❑ Other over the counter pain medicines
❑ Coumadin ❑ Plavix ❑ Heparin ❑ Lovenox ❑ Vitamin E ❑ Other blood thinning medication

Please **include** any of the above medications that you have taken in the last month, **when filling out the "Medicine Reconciliation Form".** List the dosages, how often you take them and when the last time you took them. Please include any herbal medications and other vitamins that you may also take.

Do you understand the uses of your medications and their possible interactions? ❑ YES ❑ NO

MEDICAL HISTORY for Carolinas Gastroenterology Centers

If "you" have ever had any of the following conditions, please check the box and put a short explanation:

If NONE, check here - ❑ **I have reviewed all** of the medical problems listed below and **NONE apply to me,** in the past or present.

❑Heart Problems _____

❑High Blood Pressure - Take meds for it? _____

❑High cholesterol – I take meds for it Am diet controlled

❑Kidney or Bladder disease_____

❑End Stage Renal Disease (Dialysis or transplant?)

❑Lung Problems _____

❑Sleep Apnea—Use? Oxygen CPAP BiPAP Ventilator

❑Liver Problems _____

❑ Vision or hearing: hearing aide? Contacts? Glasses?

❑Gastrointestinal Problems _____

❑Unexplained weight gain _____

❑ Have contagious illness or recent exposure _____

❑Cancer _____

❑Stroke & or Seizures _____

❑Anemia/Leukemia/Sickle Cell _____

❑Psychiatric Disorder _____

❑Depression or Anxiety _____

❑Blood Transfusion Reaction _____

❑Diabetic: Circle all you use: Insulin Oral med Diet

❑Glaucoma Right Eye Left Eye Both

❑Bleeding Disorder _____

❑Arthritis _____

❑Existing skin breakdown _____

❑Exposure to Chicken Pox within last 21 days?

❑ I could be Pregnant.

Last Menstrual Period ____/____/_____

❑ I am currently Breast feeding?

List which blood relatives have each of the illnesses listed and what form of the illness they have. ie Mom-Lung Cancer

❑Cancer _____

❑Heart Problem _____

❑Diabetes _____

❑Seizure &/or stroke_____

List all surgeries or procedures you have had, no matter how long ago. Include date if it occurred within the last 12 months.

_____

_____

_____

Have you ever used Tobacco? ❑ **Yes** ❑ **No**

Type: smoking or chewing Amt per day_____
How long? _____ Last occurrence: _____
Do you want to stop using tobacco? ❑Yes ❑No

Do you use alcohol? ❑Yes ❑No
Type: _____ Amount: _____
Frequency: _____Last occurrence: _____
Do you want to stop using alcohol? ❑Yes ❑No

Do you use recreational drugs: ❑Yes ❑No
Name: _____ Frequency: _____
Last occurrence: _____
Do you want to stop using drugs? ❑Yes ❑No

Have you ever been afraid of, hurt, or forced by anyone living in your home against your will? ❑Yes ❑No

Do you have **any learning needs** regarding today's procedure or about the care of yourself after you leave?

_____

_____

Have you experienced any of the following?

TB Signs and Symptoms:
❑Night sweats for more than 7 days
❑Cough for more than 2 weeks
❑Unexplained weight loss greater than 10 lbs.
❑History of TB, recent TB exposure or ⊕ PPD
❑Coughing up blood

Latex allergy risks:
❑Known Latex Allergy
❑Spina Bifida
❑A reaction to **handling** balloons, Band Aids, Poinsettias and/or rubber/elastic
❑A reaction to avocados, bananas, kiwi or chestnuts
❑Itching, tearing, sneezing or runny nose after a Dental procedure

***** IF YOU HAVE HAD PAIN IN THE LAST 12 HOURS*****
Please Complete the following

When did the pain start? _____
Where is the pain? _____
Is there a pattern to the pain?❑Constant❑Intermittent
❑Other: _____
On a scale of 1-10, how intense is the pain? _____
Worst pain: _____ Best pain: _____
How would you describe the pain?
_____
What activities or medications relieve the pain?
_____
What causes it to increase? _____
Does the pain affect your activities & quality of life? ❑Y❑N

Date_____ **Wt** _____ **lbs**_____**kg** ☐ Actual ☐ Stated **Outpatient location:** ☐ED ☐CED ☐ODS ☐ENDO ☐Radiology ☐ Other _____

Allergies: ☐ Denies ☐ Latex Sensitivity

Meds/Foods/Dyes/Other	Reaction	Meds/Foods/Dyes/Other	Reaction

Information obtained from: ☐ Patient/Family ☐ Pharmacy ☐ Medicine Bottles ☐ Other: _____

Primary Care Provider: _____ **Office location:** _____

Pharmacy Name: _____ **Phone number:** _____

HOME MEDICINE/ DOSE/FREQUENCY ***Patient-friendly terms only*** *(Include concentration for liquids; all routes are by mouth unless listed otherwise)* ☐ Patient not taking any home medicines ☐ Patient unclear about home medicines/doses/frequencies on entry	**Date/time of *last dose* prior to visit** *("UNK" if unknown)*	**Outpatient instructions: unless noted below, continue to take your medicines as prescribed prior to your outpatient visit.**

History Taken by: **Date:** **Time:** ☐ also see addendum form

Review list with patient/responsible party.

Following MD update/signature, faxed to next care provider(s): Name(s): **by:**

(Write "UNK" if unknown.)

Document Reviewed By MD/DDS *(MD signature not required if patient is admitted; admission/discharge form should be initiated):*

Signature: **Date:** **Time:**

New Discharge Medicines (name, dose and frequency):

☐ No new medicines

Discharge RN Signature: **Date:** **Time:**

Patient/Responsible Party Signature: ***or*** ☐ refer to ED Logicare documentation for signature

Carolinas HealthCare System

MEDICINE RECONCILIATION FORM

Outpatient Visit page 1 of 2 version 5-5-08

Patient Identifier

Patients :

1. **Always keep this form with you.** If you need help, ask a Nurse, Pharmacist, or a Doctor to help you fill out this form.

2. This list of medicines is based on information you or a family member gave the hospital or doctor's office and any available records. If you have questions about your medicines, please ask your primary care provider (doctor or nurse) or pharmacist.

3. Take this form to **all** Doctor visits and **all** medical testing (example: lab, x-ray, MRI, CT). Take this form to **all** pre-assessment visits for admission, surgery, and hospital visits (ER, hospital admission, or out-patient visit).

4. Change this form as changes are made to your medicines. If a medicine is stopped, draw a line through it and write the date the medicine is stopped. For example, if you are taking Digoxin and the doctor tells you to stop taking it on August 16, this is how you mark the form. ~~Digoxin~~ 8/16/06

5. If you have a medical test, bring this form with you. A Doctor or Nurse will look at the form and make sure it has the right information. They will give you the form back.

6. If you are in the hospital and are being discharged, you will receive a new form, which will have all of the medicines you need to take. Someone will help you read the form and will give you a copy of it. When you get the new form, throw away the old one. When you return to your doctor, take your new form with you. This form keeps you, your family, and your healthcare providers up to date on your medicines.

7. **Tell your family, friends, and neighbors about the benefits of using this form.**

HOW DOES THIS FORM HELP YOU?

By using this form, it:

1. **Reduces confusion and saves you time**.
2. **Improves communication**. Provides your family/healthcare providers with a current list of **all** of your medicines.

3. **Improves Medicine Safety.** Medicines that cannot be taken with other medicines are corrected. If you are taking two medicines that are the same, the pharmacist, doctor, or nurse can correct it.