INSTRUCTIONS FOR
Upper Gastrointestinal Endoscopy
(also called EGD: EsophagoGastroDuodenoscopy)

READ ALL INSTRUCTIONS CAREFULLY

REPORT TO:

MemorialCare Digestive Care Center, 24411 Health Center Drive, Suite 450, Laguna Hills, CA 92653.

Date _____ ***Arrival Time*** _____

1) If you are taking **blood thinning medicines like Coumadin (Warfarin), Pradaxa, Xarelto or Plavix**, please consult your doctor. You may need to stop these medications for up to 7 days prior to your procedure.

2) Do not eat or drink (except for your usually prescribed pills) after midnight on the night before your test and please eat **NO BREAKFAST** on the morning of your examination.

3) **MEDICATIONS**

   (a) On the evening prior to your examination: Take your usually prescribed medications.

   (b) On the morning of the procedure: Take your usually prescribed medications with water before 6 AM. If you are a **DIABETIC**, please discuss with your doctor scheduling this test, what you should do with your insulin on the morning of the procedure.

4) **Arrive for Endoscopy at your scheduled time.**

5) You will probably require some medication by vein for the procedure to relax you. This medication may make you sleepy for a few hours. If you receive this medication you will be required to remain here at the Endoscopy Center for 1 to 2 hours after the procedure is completed for observation.

6) If you receive this relaxing medication by vein, you cannot safely drive yourself home after the test. Therefore, plan on having someone bring you to the Endoscopy Center and return you home after the procedure. Likewise, you should not plan on operating any heavy or dangerous machinery until the day after the procedure.

7) Wear loose comfortable clothing. Please wear or bring a pair of socks with you.

 If there are any questions regarding the procedure or its scheduling, please call our office at (949) 365-8836.

Upper Endoscopy

Om P. Chaurasia, MD, FACP
Pacific Gastroenterology Medical Associates, Inc.
26421 Crown Valley Pkwy, Suite 140A
Mission Viejo, California 92691

National Digestive Diseases Information Clearinghouse

National Institute of Diabetes and Digestive and Kidney Diseases

National Digestive Diseases Information Clearinghouse
2 Information Way
Bethesda, MD
20892–3570
Tel:
(301) 654–3810
Fax:
(301) 907–8906
E-mail:
nddic@info.niddk.nih.gov

NATIONAL INSTITUTES OF HEALTH

Upper Endoscopy

Upper endoscopy enables the physician to look inside the esophagus, stomach, and duodenum (first part of the small intestine). The procedure might be used to discover the reason for swallowing difficulties, nausea, vomiting, reflux, bleeding, indigestion, abdominal pain, or chest pain. Upper endoscopy is also called EGD, which stands for esophagogastroduodenoscopy (eh-SAH-fuh-goh-GAS-troh-doo-AH-duh-NAH-skuh-pee).

For the procedure you will swallow a thin, flexible, lighted tube called an endoscope (EN-doh-skope). Right before the procedure the physician will spray your throat with a numbing agent that may help prevent gagging. You may also receive pain medicine and a sedative to help you relax during the exam. The endoscope transmits an image of the inside of the esophagus, stomach, and duodenum, so the physician can carefully examine the lining of these organs. The scope also blows air into the stomach; this expands the folds of tissue and makes it easier for the physician to examine the stomach.

The physician can see abnormalities, like ulcers, through the endoscope that don't show up well on x-rays. The physician can also insert instruments into the scope to remove samples of tissue (biopsy) for further tests.

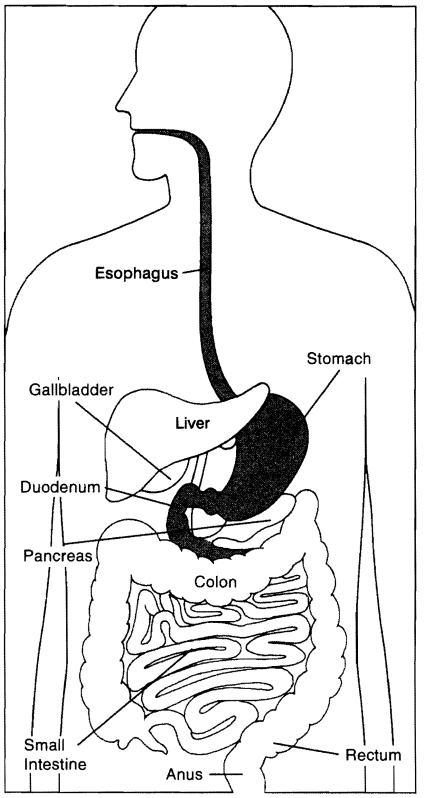
Possible complications of upper endoscopy include bleeding and puncture of the stomach lining. However, such complications are rare. Most people will probably have nothing more than a mild sore throat after the procedure.

The procedure takes 20 to 30 minutes. Because you will be sedated, you will need to rest at the physician's office for 1 to 2 hours until the medication wears off.

Preparation

Your stomach and duodenum must be empty for the procedure to be thorough and safe, so you will not be able to eat or drink anything for at least 6 hours beforehand. Also, you must arrange for someone to take you home—you will not be allowed to drive because of the sedatives. Your physician may give you other special instructions.

The Digestive System



Your physician has fact sheets on other diagnostic tests:

- Colonoscopy
- Sigmoidoscopy
- ERCP
- Upper GI Series
- Lower GI Series

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health

NIH Publication No. 98–4333
June 1998

MemorialCare DIGESTIVE CARE CENTER, an Affiliate of SCA

Dear Patient:

You are being provided with this packet of information to prepare you in advance for your appointment at the Digestive Care Center. **PLEASE TAKE TIME TO REVIEW THIS ENTIRE PACKET and complete paperwork before arriving at the Center.** Please feel free to call us at **949-586-9386** if you have any questions or visit our website at www.digestivecarecenterca.org. Our goal is to make your visit with us a positive and pleasant experience.

REQUIRED FORMS:

- Registration Form: Complete all of your insurance and contact information accurately
- Medication Form: Complete all areas listed on form related to ALL medications you take.
- Assignment of Benefits – read, initial, sign and date form.
- Record of Disclosure Form: Informs us on how you want us to communicate with you.

PREPARATION:

- Review these instructions as soon as possible and follow them as requested by your doctor. Your pre-procedure preparation will directly influence the outcome of your procedure.
- Questions regarding your prep, medications to discontinue or medications you should or should not take the day of your procedure must be discussed with your physician. For questions, please contact your doctor's office.

DAY OF PROCEDURE:

- You MUST bring a photo I.D. and your insurance card(s) along with required forms.
- Payment due at time of service – bring choice of payment if you have a co-pay or deductible due
- Valuables: Leave ALL valuable jewelry at home. The Center is not responsible for lost or broken valuables.
- *Advanced Directives Policy:* If you have an executed Advanced Directive, please bring a copy for our files.
- Driver: You MUST have a driver. If you have not arranged for a driver to sign you out your procedure will be cancelled.

NOTIFICATIONS:

- **One** day prior a nurse will call to pre admit you, review paperwork, directions, parking, and exact time we need you to arrive at the Center. *Please note that your time is adjusted by our facility to accommodate your physician's schedule and to allow time for the admitting process as needed.*

POST PROCEDURE:

- You MUST give permission to who you will allow us to disclose your post procedure results to.
- If you want your doctor to speak to a family member or friend, we ask that they wait in our lobby. If they leave, we cannot guarantee your doctor will be available again.
- You will be provided with detailed discharge instructions prepared by your physician specific to your procedure findings. Please review your instructions once you are more awake and BEFORE RESUMING ANY MEDICATIONS OR EXERCISE.

CANCELLATION POLICY:

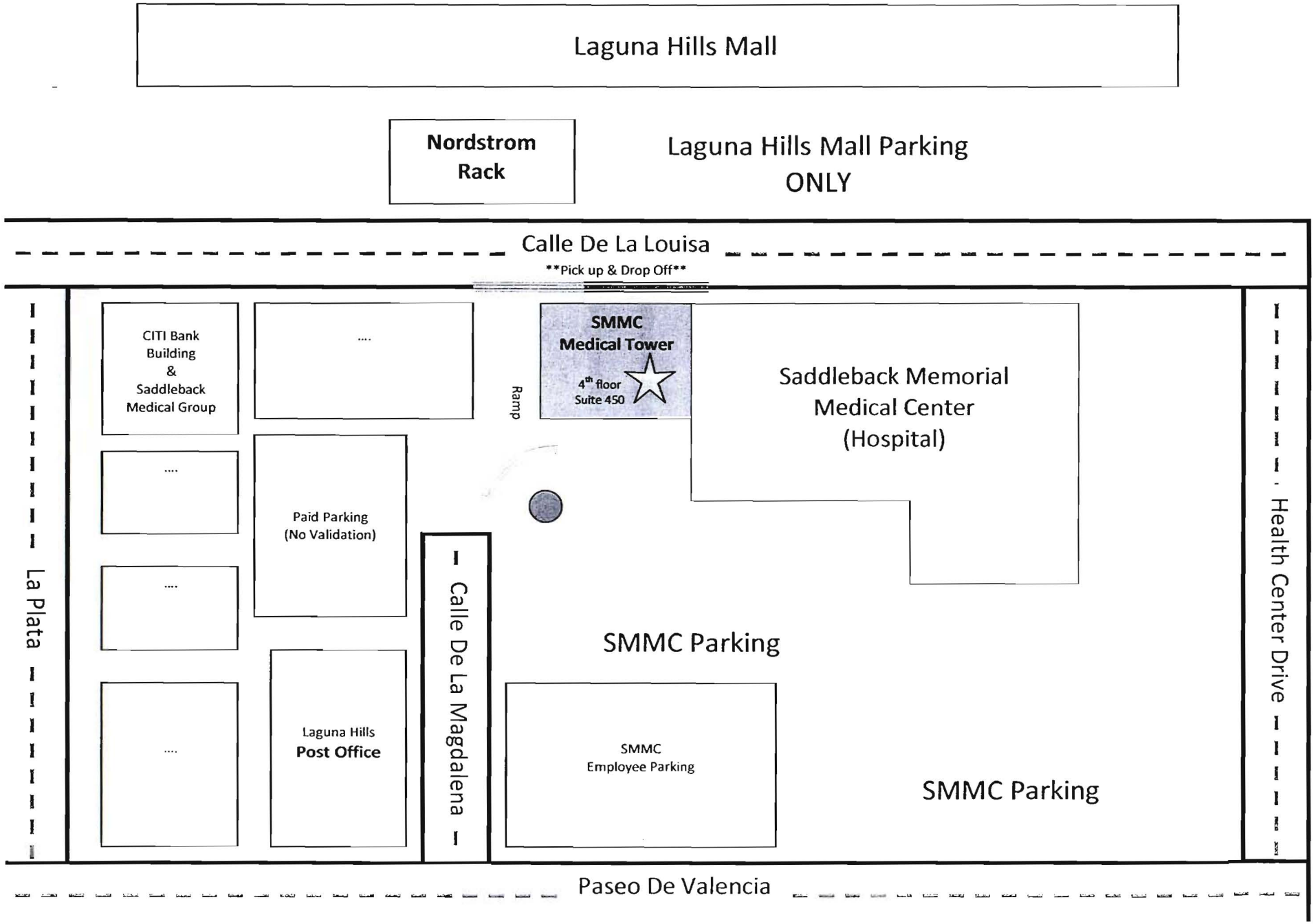
- You MUST notify the Center **72 hours prior to your scheduled procedure to avoid a $200 cancellation fee for the Center**. The Center will note the date and time you called to cancel. Your physician will send us a request to cancel you or provide a request to reschedule you once you have notified them.
- You also MUST notify your physician that you wish to cancel. Please check their cancellation policy.

The Digestive Care Center Management Team

***Digestive Care Center an affiliate of* SCA**

MemorialCare Digestive Care Center, *an affiliate of SCA*

24411 Health Center Drive, Ste. 450
(Entrance on Calle De La Louisa)
Laguna Hills, CA 92653
949-586-9386



DIGESTIVE CARE CENTER, *an affiliate of SCA*
949-586-9386
ASSIGNMENT OF BENEFITS

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YOU WILL BE BILLED BY THE FOLLOWING FOR YOUR PROCEDURE: 1) THE FACILITY 2) PHYSICIAN PERFORMING PROCEDURE 3) PATHOLOGY LAB - IF A SPECIMEN IS TAKEN _____ Patient Initials

****

RELEASE OF INFORMATION:

I authorize the Digestive Care Center to provide all patient's recorded information, including patient's medical record, to the patient's insurance company, to any healthcare service plan or worker's compensation carrier, a designated attorney or legally responsible individual or corporation.

ASSIGNMENT OF BENEFITS: Designation of Authorized Representative

I hereby appoint as my designated authorized representative, and assign to above-named facility all my rights, title, and interest in and to, and relating in and to the recovery of, any and all health care and/or surgical benefits otherwise payable to me or to which I am entitled for medical treatment, including major medical, rendered by provider. I also specifically authorize my authorized representative to do the following on my behalf:

1) File and prosecute any required appeal or grievance with my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative including filing litigation or arbitration on my behalf and on behalf of my designated authorized representative.
2) File any required complaint, appeal or grievance with the state insurance department, Department of Labor or any other regulatory agency for payment of medical claims submitted by or on behalf of my authorized representative.
3) Discuss my personal health information with my health plan and/or health insurer, and obtain a summary plan description, insurance policy and/or other plan documents.

I hereby authorize direct payment to the Digestive Care Center of any insurance benefit to which I am entitled for treatment services rendered by the Center, but not to exceed the amount of my indebtedness to the Center.

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment to the Digestive Care Center of any insurance benefit to which I am entitled for treatment services rendered by the Center, but not to exceed the amount of my indebtedness to the Center.

****PATIENTS WITH A (POS) PLAN:**

The Digestive Care Center is to bill under my POS option, which is not covered under my HMO option. My benefits will be processed in or out of network, based on coordination of benefits. An authorization for out of network will be submitted only if applicable according to your health plan and today's charge(s) will be billed accordingly.

I agree and understand the above terms and guidelines. I am aware that additional cost may be my responsibility according to my benefits. I agree and wish to pursue utilizing my POS option. **INITIAL**_____

FINANCIAL AGREEMENT AND RESPONSIBILITY:

If you would like the Center to bill your insurance provider, you must provide us with a copy of your insurance card(s), proof of identity and completed forms of required information all of which is required upon admission. Necessary forms will be completed to help expedite insurance payments. Digestive Care Center **does not assume responsibility** for verification of insurance and coverage for my procedure. **INITIAL**_____

PLEASE INITIAL FOLLOWING:

____ I understand that verification of insurance is not a guarantee of payment and that it is my responsibility to contact my insurance company to understand my benefits for services rendered and to make sure that payment has been made to the center.

____ All professional services rendered are charged to the patient. I further understand and agree, either as a patient or as the patient's agent that I am financially responsible to the Digestive Care Center for services being rendered to me today. This applies to any out of pocket responsibility such as copay's , deductibles, co-ins or non-payment from the insurance company. If I receive payments from my insurance carrier(s) for my services rendered, I will forward the payment immediately to the Center. In the event of non- payment, I agree to bear the cost of collection and / or court costs and reasonable legal fees if required. I also understand that a 12% annual interest will accrue from the date the account goes into collection process due to non-payment.

____ I understand that there will be a $50.00 fee placed on every returned check.

CO-PAYMENTS AND DEDUCTIBLES:

Co-payments and deductibles are due at the time of service. Co-insurance or any balance is due upon receipt of statement.

I have read the above policy and understand that I am financially responsible for paying for my services rendered at the Digestive Care Center.

_____ _____

Patient Name (PLEASE PRINT) **Patient Signature/Parent/Guardian/Conservator**

_____ _____

Date and Time **Witness**

DIGESTIVE CARE CENTER, *an affiliate of SCA*
24411 Health Center Drive, Suite 450
Laguna Hills, CA 92653
949-586-9386

PATIENT REGISTRATION - *CONFIDENTIAL*

Name: Last	First	MI:	**DATE:**
Home Address:	City	State	Zip Code
Birth Date:	S.S.#:	Sex: M or F	Marital Status: S M W D
Main Number:	2nd Phone Number:		Driver License#:
Employer:			Work phone:
Nearest relative:	Phone:		Referred By:

PRIMARY INSURANCE INFORMATION

Insurance Carrier:		**Insurance ID#**	**Insurance Group#**
Insured's Name	Date of Birth	Insured's SS#	Patient's Relationship to the Insured: Self Child Spouse
Address:	City	State	Zip Code
Insured's Phone #		Insured's Work #	

SECONDARY INSURANCE INFORMATION

Insurance Carrier:		**Insurance ID#**	**Insurance Group#**
Insured' s Name:	Date of Birth	Insured's SS#	Patient's Relationship to the Insured: Self Child Spouse

I certify that the information I have reported with regard to my insurance coverage is correct.

Upon admission you will receive verbal information regarding the following items. You will be provided with written information on items you select. Please check the following yes or no:

HIPAA INFORMATION: NOTE: You are entitled to receive a paper copy of the HIPAA notice at any time
☐ **YES** I wish to receive HIPAA Notice of Privacy Practice ☐ **NO** Decline receipt of HIPAA Privacy Notice

ADVANCED DIRECTIVES:
☐ **YES** I have provided a copy of my Advanced Directives ☐ **NO** I did not bring a copy to the Center
☐ **No,** I do not have an Advanced Directives

INFORMATION ON ADVANCED DIRECTIVES:
☐ **YES** I wish to receive information regarding this ☐ **NO** Decline receipt of this document

PATIENT RIGHTS & RESPONSIBILITIES:
☐ **YES** I wish to receive a copy of Patient Rights ☐ **NO** Decline receipt of this document

Physician Ownership Disclosure is posted in admit area.
☐ **YES** I wish to receive a copy of Physician Ownership Disclosure ☐ **NO** Decline receipt of this document

Secure Phone Option: I authorize the Center staff to leave a recorded message on following number(s) regarding: Personal health information, appointment confirmation, lab results, follow up phone calls and billing inquiries. Without this authorization we are not allowed to leave a message.

Authorized phone number(s): _____ _____
Center staff may speak to or leave a message with: _____
Email address: DDC is authorized to email information to me @ _____

PERSONAL VALUABLES: I understand that the facility assumes no responsibility for patients Valuables, and shall not be liable for loss or damage to personal property.

Patient's Signature _____ Print Name_____

Digestive Care Center, *an affiliate of SCA*

949-586-9386

PATIENT MEDICATION LIST

So that we may maintain the highest quality in care and safety, please fill in ALL MEDICATIONS that you take. Bring this completed form with you on the day of your procedure. Please be sure to include ALL prescription medications, any over the counter products, including herbal products and narcotic or pain medications.

- **The first nurse to interview the patient will review completion of this form with patient.**
- **Circle all sources of information:** Patient Caregiver Rx bottle EMS Primary provider Other _____

ALLERGIES AND ADVERSE DRUG REACTIONS: _____

_____

YOUR LIST (Please Print)						
Medication Name	Dosage Strength	Times per Day	Last Taken		Asked to stop Before procedure	NOTES
			Date	Time		
1.					Y N	
2					Y N	
3					Y N	
4					Y N	
5					Y N	
6.					Y N	
7.					Y N	
8.					Y N	
9.					Y N	
10.					Y N	
Over The Counter Medications, Vitamins, Herbals, etc.					Y N	
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	
					Y N	

The above noted list is true, correct, and complete to the best of my knowledge and belief:

_____ _____

PATIENT SIGNATURE **DATE**

DO NOT SIGN OR DATE THIS FORM UNTIL DURING ADMISSION AT OUR FACILITY ON THE DAY OF YOUR PROCEDURE

Admit Nurse: **List reviewed with patient:**	_____ _____ _____ **Signature** **Date** **Time**
Comments:	

Discharge Note:	
DO NOT take NSAIDS for _____days **NSAID List provided**	**Resume medications on** _____
Discharge Nurse: **Orders to resume medication(s) reviewed with patient/family:**	_____ _____ _____ **Signature** **Date** **Time**
Comments:	

Physician Signature	**TRANSFER RECONCILIATION**
_____ _____ _____ **Date** **Time**	• A copy of this form will be placed in transfer packet • Procedure performed and medications received while at the Center will be reported upon transfer.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- ☐ Home telephone _____
  - ☐ O.K. to leave message with spouse
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work telephone_____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number_____
  - ☐ O.K. to exchange information with referring doctors and treatment facilities
- ☐ Other_____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PRINT NAME BIRTH DATE

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. **Note: Uses and disclosures of PHI may be permitted without prior consent in an emergency.**

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom (Address or FAX)	Description of/Purpose of Disclosure	by Whom