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

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

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.

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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.

Your physician has fact sheets on other diagnostic tests:
- Colonoscopy
- ERCP
- Sigmoidoscopy
- Upper GI Series
- Lower GI Series
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

Patient Letter Reviewed 01 2015
ASSIGNMENT OF BENEFITS

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

Release of Information:

I hereby authorize the Digestive Care Center to release 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:

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

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.

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.

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

PATIENT REGISTRATION - CONFIDENTIAL

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

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<tr>
<th>Insurance Carrier:</th>
<th>Insurance ID#:</th>
<th>Insurance Group#:</th>
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<table>
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<tr>
<th>Insured’s Name</th>
<th>Date of Birth</th>
<th>Insured’s SS#</th>
<th>Patient’s Relationship to the Insured:</th>
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<th>Address:</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Insured’s Phone #</th>
<th>Insured’s Work #</th>
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**SECONDARY INSURANCE INFORMATION**

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<th>Insurance Carrier:</th>
<th>Insurance ID#:</th>
<th>Insurance Group#:</th>
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<tr>
<th>Insured’s Name</th>
<th>Date of Birth</th>
<th>Insured’s SS#</th>
<th>Patient’s Relationship to the Insured:</th>
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**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):

  ___________________________ ___________________________
  ___________________________ ___________________________

  **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 _______________________
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:

<table>
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<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Last Taken</th>
<th>Asked to stop Before procedure</th>
<th>NOTES</th>
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<td>Y N</td>
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<td>10.</td>
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<td>Over The Counter Medications, Vitamins, Herbals, etc.</td>
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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 Resume medications on
NSAID List provided
Discharge Nurse: Orders to resume medication(s) reviewed with patient/family: Signature Date Time

Comments:

Physician Signature ___________________________ DATE

TRANSFER RECONCILIATION
- 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.
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.**

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<thead>
<tr>
<th>Date</th>
<th>Disclosed to Whom (Address or FAX)</th>
<th>Description of/Purpose of Disclosure</th>
<th>by Whom</th>
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