Columbia Gastrointestinal Endoscopy Center

PLEASE REVIEW PACKET AT LEAST 7 DAYS BEFORE PROCEDURE

Please COMPLETE and bring the 2 attached forms, your Driver's License/Photo ID and current insurance cards to prevent any check-in delays. These forms look like the ones you filled out in the office, but we are required to maintain separate records from your doctor's office. Please complete the ENTIRE medical history to prevent any delays.

- **COPAYS AND DEDUCTIBLES are due when you arrive. BEFORE YOUR PROCEDURE, please call the Columbia Endoscopy Center Verification of Benefits department (Nashville, Tennessee) 1-844-235-0201 to find out any copays that will be due on the day of service. Please call your insurance provider for questions regarding your deductible, out of pocket, coverage of services or copays. Please do not call the doctor's office for procedure/facility/anesthesia billing questions, they will be unable to assist you. IF YOU PAID A FEE AT THE PHYSICIAN'S OFFICE, that is for the physician's services. That is not applied to the Columbia Endoscopy Center facility fee. You may call 1-866-809-1220 or email Statement.questions@amsurg.com for any bills you receive after your procedure.**

- **PROCEDURE LOCATION:** Columbia GI Endoscopy Center, 2739 Laurel Street, SUITE 1B, Columbia, S.C. 29204. (803) 254-9588 for directions.

- **YOUR DRIVER MUST REMAIN ON THE PREMISES,** either in the waiting room or in the car. Your procedure will be cancelled if you do not have a driver. We will ask for a cell number for those waiting in the car. Due to space constraints, please have only 1 person with you (driver). The estimated waiting time is 45 minutes - 2 hours. Times vary. We ask that no children accompany you due to the health risks to our elderly patients.

- If the pharmacy states they cannot find your prescription, please ask them to look further back in your history. They will only look back for 2 weeks for any prescriptions.

- Due to space constraints and privacy, visitors aren't allowed in the Pre-op area, unless there are special needs. Dress comfortably (2-piece outfit). Please leave all valuables at home.

- When you are ready to be discharged, your driver will be brought back and given your post op instructions. Please make sure that your driver (OVER THE AGE OF 18) is someone that you don't mind hearing your instructions.

- We use a texting service to send appointment reminders before your procedure. We will also send a text message to check on you after your procedure. Please be sure to provide your mobile number so we can communicate with you.

Questions regarding Prescriptions, Prep and Instructions please call the physician's office 803-799-4800
To avoid a physician's CANCELLATION FEE, call ASAP if you need to CANCEL or RESCHEDULE

Columbia Gastrointestinal Endoscopy Center

Please check: ☐ **Bristow** ☐ **Galan** ☐ **Kimbrough** ☐ **Mann** ☐ **Postic** ☐ **Villanueva** **Account #** _____

PATIENT INFORMATION

PATIENT:_____ SOCIAL SECURITY #:_____

ADDRESS:_____DATE OF BIRTH: _____ AGE: _____

CITY_____ STATE_____ZIP_____ COUNTY_____

I authorize Columba GI Endoscopy Center to leave messages pertaining to my healthcare or finances at the following numbers:

CELL _____HOME_____(Please inform receptionist if you decline voicemail messages)

E-mail Address_____ Sex at Birth: ☐ Female ☐ Male

FAMILY/REFERRING PHYSICIAN _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

RACE: ☐ African America ☐ Caucasian ☐ American Indian ☐ Asian Other_____

ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Latino HAVE YOU HAD A PREVIOUS PROCEDURE AT OUR CENTER? ☐ Yes ☐ No

DO YOU HAVE AN ADVANCED DIRECTIVE or LIVING WILL? ☐ Yes ☐ No IF NOT, WOULD YOU LIKE INFORMATION? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS_____CITY, STATE, ZIP_____

MEMBER # _____ GROUP# _____

NAME OF INSURED_____INSURED SOCIAL SECURITY _____

INSURED DATE OF BIRTH _____RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS:_____CITY, STATE, ZIP _____

MEMBER # _____ GROUP#_____

NAME OF INSURED:_____INSURED SOCIAL SECURITY:_____

INSURED DATE OF BIRTH _____RELATIONSHIP TO PATIENT _____

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE _____

Procedure and Billing Communication Authorization/ Emergency Contact

I authorize Columbia GI Endoscopy Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

CONTACT _____ Phone # _____ RELATIONSHIP _____

Emergency contact if different from above: _____ Phone # _____ RELATIONSHIP _____

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Signed (Patient or Responsible Party) _____Date_____

Columbia Gastrointestinal Endoscopy Center

MEDICAL HISTORY. Please COMPLETE ENTIRE FORM. (We do not have access to your physician's records)

I have not had anything by mouth (including medication) since _____ a.m. p.m. ☐ Today ☐ Yesterday
COLONOSCOPY PATIENTS - Were you on a clear liquid diet **ALL DAY** yesterday and today? ☐ Yes ☐ No

Which procedure are you having done? (Check all that apply)
☐ Colonoscopy ☐ EGD-Upper endoscopy
☐ Esophageal Dilation ☐ Sigmoidoscopy

Colonoscopy patients, which prep did you use?
☐ Gavilyte, (Gallon jug) ☐ Clenpiq ☐ Suflav ☐ Suprep
☐ Sutab ☐ Plenvu, other _____.
What time did you finish drinking prep? _____ Describe results:
☐ Clear ☐ Yellow ☐ Brown Blood seen? ☐ Yes ☐ No

Why are you having the procedure?
☐ First colonoscopy ☐ Age related colon screening
☐ History of colon polyps ☐ History of Colon Cancer
☐ Family history of colon cancer _____
☐ Abdominal pain ☐ Ulcerative colitis ☐ Crohn's Disease
☐ Diarrhea ☐ Constipation ☐ Rectal bleeding ☐ Blood in stool ☐ Last colonoscopy performed when? _____
☐ Reflux ☐ Heartburn ☐ Barretts ☐ Nausea ☐ Vomiting
☐ Difficulty swallowing, ☐ Anemia, Other _____

Females/ Have you had a hysterectomy or tubal ligation ☐ Yes ☐ No
Would you like a pregnancy test? ☐ Yes ☐ No

☐ **I HAVE NO MEDICAL/HEALTH CONDITIONS or**
Please check all that apply:

I have brought ☐ Glasses ☐ Dentures ☐ Hearing aid ☐ Contacts

☐ Parkinsons disease ☐ I use a Walker, Cane, Wheelchair

☐ I have fallen in the past year

☐ Diabetes Do you take insulin? ☐ Yes ☐ No

Did you check your blood sugar today? ☐ Yes ☐ No
Result Time

☐ **BLOOD THINNER USE** Last dose taken date _____
Plavix, Eliquis, Xarelto, Pradaxa, Coumadin, _____

☐ **HEART DISEASE** ☐ CAD ☐ Previous Heart attack
☐ High blood pressure ☐ High Cholesterol ☐ Heart Stents
☐ Atrial fibrillation ☐ Pacemaker ☐ Artificial heart valve
☐ Stroke ☐ CHF ☐ other heart problems

☐ **CARDIAC DEFIBRILLATOR** (Please call the office, we cannot do your procedure here)

☐ **SLEEP APNEA** Do you use a CPAP? ☐ Yes ☐ No

☐ COPD ☐ Asthma ☐ Chronic Bronchitis ☐ other breathing issues _____

☐ HIV ☐ Hepatitis A/B/C ☐ Cirrhosis ☐ Other liver disease

☐ Glaucoma ☐ Arthritis ☐ Hypothyroid ☐ Hyperthyroid

☐ Kidney disease ☐ Dialysis ☐ Shunt in arm

☐ Cancer Type _____
☐ No BP or IV sticks in one of my arms ☐ right ☐ left

☐ Artificial pins or plates (ex. knee, hip, shoulder)
Location _____ Year performed _____

☐ Internal Stimulators (nerve, spinal, bladder) Location _____ Is the stimulator off? ☐ Yes ☐ No

☐ Seizure Disorder Date of last seizure _____

☐ Other medical conditions not listed _____

☐ Never Smoker ☐ Former smoker ☐ Current Smoker/vape
Did you smoke today ☐ No ☐ Yes Amt smoke _____ per day

☐ Social/Occasional alcohol ☐ Daily alcohol ☐ Never

☐ Illicit Drug use (marijuana, etc.)

☐ I have a history of substance abuse (alcohol, opiates, etc.) that may increase my anesthesia requirement.

☐ **I have no allergies, sensitivity or reactions to medications, foods, material, environmental factors**

LIST all allergies, sensitivities and reactions: (include over the counter meds & food allergies)

Med, food, etc.: _____ Reaction: _____
Med, food, etc.: _____ Reaction: _____
Med, food, etc.: _____ Reaction: _____
Med, food, etc.: _____ Reaction: _____

☐ **I have had no surgical procedures OR**

LIST all surgical procedures:

_____
_____
_____
_____
_____
_____

☐ **I take no medications or supplements OR**

LIST all medications: IMPORTANT!! (List ALL meds, doses (mg), how often (daily, twice a day) and last taken)

Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____
Med _____ Last taken_____

(STAFF USE ONLY)
Ht_____ WT_____ BP_____ T_____HR_____ RR____ O2_____

Driver's Name _____ **Do you have an Advance Directive / Living will?** ☐ No ☐ Yes
Driver's Phone # _____ ☐ **In Waiting room** ☐ **In Car** ☐ **Bring Driver to Recovery** ☐ **Don't bring back**
I understand my driver must remain on the premises. I understand the Center is not responsible for any valuables I have brought with me.
Patients Signature _____ **Date** _____

Columbia Gastrointestinal Endoscopy Center
2739 Laurel Street, Suite 1B
Columbia, SC 29204
803 254-9588

Billing and Charges

Please contact your insurance provider and our billing department BEFORE your procedure for your deductible, copayment information and coverage of services. Any amounts that have not been met are your responsibility and will be collected upon your arrival. Our billing office will attempt to contact you via text messaging or phone to inform you of your financial responsibility. If you have not heard from them, please call them at 1-844-235-0201. The Columbia Endoscopy Center has separate billing from Columbia Gastroenterology Associates (physician's office). Any payments you made at the doctor's office are applied to the physician's fee and not to your procedure facility fee.

YOU WILL RECEIVE A BILL FROM EACH OF THE FOLLOWING:

1. ***Facility fee****: This charge is for where the procedure was performed. For questions regarding bills you have received* ***AFTER*** *your procedure, please call Columbia ASC, LLC (d.b.a. Columbia GI Endoscopy Center)* ***1-866-809-1220.*** *The billing office is in Nashville, Tennessee You can also email* ***Statement.questions@amsurg.com*** *for any questions, concerns, or billing issues. The physician's office* ***cannot answer*** *any procedure insurance related questions. Please call our billing office and/or your insurance provider for assistance.*

2. ***Anesthesia fee:*** *Anesthesia Group: Amsurg Columbia Anesthesia, LLC. The billing office is in Nashville Tennessee* ***1-866-809-1220.***

3 ***Physician's fee:*** *Columbia Gastroenterology Associates (physician's office). This is a fee for the physician performing your procedure. The phone number is* ***803-799-4800.***

4 ***Pathology fee:*** *If you have biopsies taken during your procedure, the specimens will be sent to Columbia Gastroenterology Pathology Services. The pathologist analyzing your biopsy will bill you for their professional Services through Vizia Diagnostics. If your insurance requires a particular laboratory for specimen* ***pathology****, please let the staff know upon arrival. The endoscopy center staff cannot verify this on all patients and* ***will not take responsibility*** *for sending specimens to an out of network lab. Pathology is different from laboratory blood work. When contacting your insurance provider to verify coverage, make sure you inform them that this is for pathological analysis and not blood work.*

Patient's Rights and Responsibilities and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- *To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.*
- *To receive considerate, respectful, and dignified care.*
- *To be provided privacy and security during the delivery of patient care service.*
- *To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.*
- *To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.*
- *When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.*
- *To make decisions regarding health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.*
- *Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly.*
- *Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.*
- *To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment, or reprisal.*
- *Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.*
- *To be informed of their right to change providers if other qualified providers are available.*
- *Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.*
- *To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.*
- *To know which facility rules and policies apply to his/her conduct while a patient.*
- *To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patients' rights.*
- *To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.*
- *To examine and receive an explanation of his/her bill regardless of source of payment.*
- *To appropriate assessment and management of pain.*
- *To be advised if the physician providing care has a financial interest in the surgery center.*
- *Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and to support participation of the caregiver in decisions affecting medical treatment.*
- *Be advised as to the absence of malpractice coverage.*

PATIENT RESPONSIBILITIES:

- *To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.*
- *To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.*
- *To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.*
- *To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.*
- *To accept personal financial responsibility for any charges not covered by their insurance.*
- *To be respectful of all healthcare professionals and staff, as well as other patients.*
- *The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care.*
- *The patient is responsible for keeping appointments and notifying the physician or facility when unable to do so.*
- *The patient and/or patient representative is responsible for disposition of patient valuables.*
- *In the case of pediatric patients, a parent or guardian is responsible to remain in the facility for the duration of the patient's stay in the facility. The parent or legal guardian is responsible for participating in decision making regarding the patient's care.*
- ** The patient is responsible for his/her actions should he/she refuse treatment or not follow the physician's orders.*
- ** The patient is responsible for being considerate of the rights of other patients, visitors, and facility personnel.*

If you need an interpreter:

If you need an interpreter, **please let us know** *and one will be provided for you. If you have someone who can translate confidential, medical, and financial information for you, please make arrangements to have them accompany you on the day of your procedure.*

Rights and Respect for Property and Person Privacy and Safety

The patient has the right to:

- *Exercise his or her rights without being subjected to discrimination or reprisal.*
- *Voice a grievance regarding treatment or care that is, or fails to be, furnished.*
- *Be free from all forms of abuse or harassment*
- *Personal privacy*
- *Receive care in a safe setting*
- *Confidentiality of personal medical information.*
- *Be fully informed about a treatment or procedure and the expected outcome before it is performed.*

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in South Carolina Statutes §44-77-10-160. In the State of South Carolina and federal law give all competent adults, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If certain treatments are not wanted, they have the right to tell their doctor, either orally or in writing, they do not want them. If they want to refuse treatment, but they do not have someone to name as their agent, you can sign a living will.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Columbia Gastrointestinal Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end-of-life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances: *If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.*

The following are the names and/or agencies you may contact:

Edwina Smith, BSN, RN-Center Director
Columbia Endoscopy Center
2739 Laurel Street, Suite 1B
Columbia, SC 29204
803 254-9588

You may contact the state to report a complaint.

South Carolina Health & Human Services
PO Box 8206
Columbia, South Carolina 29202
1-888.549.0820
State Web site: https://www.scdhhs.gov/

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman. **Medicare Ombudsman Web address:** *https://www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home*
Medicare: *www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)*

Office of the Inspector General: *http://oig.hhs.gov*

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
3 Parkway North Blvd., Suite 201
Deerfield, Illinois 60015
Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

Physician Financial Interest and Ownership: **Physician Financial Interest and Ownership:** The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Walter J. Bristow, MD, Jorge L. Galan, DO, Edward E. Kimbrough, MD, Georges T Postic, MD, James M. Mann, MD, Faith Villanueva MD