# *EGD*

Esophagogastroduodenoscopy

Upper GI endoscopy is a special examination of your upper gastrointestinal (GI) tract for problems like ulcers, foreign objects, or tumors. During the endoscopy a long flexible tube or endoscope, is passed through the mouth to the esophagus, stomach, or small intestine for direct viewing. Based on fiber optics, the ability of flexible glass fibers to transmit light, endoscopy is performed by a physician who is specially trained in the procedure.

**How Long**?

Endoscopy itself takes about 30 minutes. Allow time for arrival and 30-60 minutes for recovery.

**During your stay**:

You will be asked to change in to a gown. Your throat will be anesthetized with spray. An IV will be started so your physician or nurse can give IV sedation. Your pulse, blood pressure and oxygen levels will be monitored.

**Afterwards**:

1) Follow your doctor's instructions.
2) You must have someone to drive you home after the procedure, due to the IV sedation you will have received.
3) You may have a sore throat for about 24 hours.
4) Burping helps to relieve the bloated feeling you may experience.
5) Biopsy reports take one week and will be forwarded to your doctor.
6) Follow up with your doctor as instructed.

**Possible complications:**

Complications with the procedure are extremely rare.
Localized irritation of the vein may occur at the IV site. A tender lump develops which may remain for several weeks but goes away eventually. Other risks include drug reactions and complications from unrelated diseases such as heart attack or stroke. Death is extremely rare, but remains a remote possibility.

I have read and fully understand the above information

.

_____ _____

patient signature nurse signature

_____

date

**Derby Family MedCenter**
1101 N. Rock Road
Derby, Kansas 67037

**PATIENT FINANCIAL POLICY & INFORMED CONSENT**
Appointments (316) 788-6369 Business Office (316) 789-1149

**WELCOME**
We are committed to providing you with the best possible care and we are pleased to discuss fees with you at anytime. *Your clear understanding of our Patient Financial Policy is important to our professional relationship.* Please ask if you have any question about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

All patients must complete our *Patient Information Sheet* before seeing the doctor. It is your responsibility to notify our office of any patient information changes (i.e., address, name change, insurance, phone numbers, etc.)

**INSURANCE**
We will file your primary and secondary insurance claims as a courtesy to the patient by the current copy of your insurance cards on file. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to deductibles, co-payments non-covered chares, or "usual and customary" charges. Your insurance is between the patient, subscriber's employer, and insurance carrier. We will supply any factual information as necessary. **You are responsible for the timely payment of your account.** If there is no insurance responsibility, payment is due at the time services are rendered.

**REFERRALS:**
If a referral form is required for your insurance carrier, it is the patient's responsibility to obtain this form from their primary care physician prior to any appointments. Failure to obtain this form may result in a reduction of benefits by your insurance carrier. The account responsible party will be responsible for any charges incurred by the patient that is denied by the insurance due to the lack of insurance authorization.

**CO-PAYMENTS:**
Co-payment is due at the time you check in at the front desk **PRIOR** to being seen by the doctor.

**UNPAID BALANCES:**
**We ask that payment in full be made at the time of service.** If your insurance company has not paid the full balance, you will be sent a statement notifying you of the amount due, due upon receipt. **Any balances that are patient responsibility are due and payable in full.** *We accept cash, checks, money orders, or any of the following credit cards for payment: Visa, MasterCard, Discover or American Express.* Any overdue balances may be considered for collections and services terminated. To request an itemized copy of your current year's charges, you may be required to send a written request along with a $15.00 payment to our business office.

**LATE FEE**
You will **not** be assessed a **LATE FEE** on services if the Patient Balance shown on your current statement is paid in full within 56 days of the initial statement date. The **LATE FEE** will be a flat rate of $5.00 a statement after the 2nd consecutive patient responsibility statement.

**COLLECTION COSTS AND ATTORNEY FEES:**
In the event Family MedCenters. PA must incur collection costs or attorney fees in connection with your account, as permitted by applicable law, you agree to pay the reasonable costs of collection, including, but not limited to, court costs, attorney fees and collection agency fees.

**RETURNED CHECKS:**
The fee for a returned check is **$30.00** payable by cash, credit card, or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a "Cash Only" basis following any returned check.

**MINORS:**
The parent(s) or guardian(s) are responsible for full payment and will receive the billing statements. *Your signature is our release to treat an unaccompanied minor.*

**PERSONAL ITEMS:**
Please keep your personal items with you during office visit(s). Personal items are the responsibility of the patient.

**MISSED APPOINTMENTS:**
You may be charged for any missed appointment or late cancellation without a 24-hour prior notice.

I fully understand and agree to the above mentioned office policies of Family MedCenters, PA.

_____
PATIENT NAME (Please Print)

_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

We appreciate the opportunity to provide our services for your medical needs. Your assistance and cooperation will be most appreciated. Should you have any questions or concerns, please contact a business office representative at (316)789-1149

DERBY AMBULATORY SURGERY CENTER

1101 N. ROCK RD. BLDG. 2 DERBY, KS

PHONE - 771-9999

**INSTRUCTIONS FOR PATIENTS SCHEDULED FOR EGD OR COLONOSCOPY**

**7 DAYS PRIOR TO SURGERY:**

Stop taking aspirin and any medications containing aspirin (acetylsalicylic acid) seven (7) days before surgery. These medications may cause you to bleed **more** easily. Below is a list of some examples of medications containing aspirin.

| | | | | | | |
|---|---|---|---|---|---|---|
| Alka-seltzer | Bayer | Cope | Easprin | Florida | Pepto-Bismol | Vanquish |
| Anacin | BC Powder | Darvon | Ecotrin | Goody's | Percodan | ZORprin |
| Ascriptin | Bufferin | Disalcid | Empirin | Midol | Sal flex | |
| Aspirin | Compound | Doan's Pills | Excedrin | Mono-Gesic | Trilisate | |

Stop taking the following arthritis, non-steroidal anti-inflammatory drugs (NSAID's), or pain medications seven (7) days before surgery. These medications may cause you to bleed **more** easily.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Advil | Arthrotec | Clinoril | Ibuprofen | Meloxicam | Nalfcon | Orudis | Rufen |
| Aleve | Butazolidin | Dolobid | Indocin | Medipren | NapralPAC | Pamprin-IB | Suprol |
| Anaprox | Cataflam | Etodolac | Lodine | Mobic | Naprosyn | Ponstel | Vioxx |
| Ansaid | Celebrex | Feldene | Meclomen | Motrin | Nuprin | Relafen | Voltaren |

** Stop taking all herbs, vitamins, and over the counter medicines seven (7) days prior to your procedure. The medicines may cause an adverse reaction with some sedative/anesthetic agents.

** You may take Tylenol (acetaminophen) for pain up until the day of surgery.

**Patient needs to be off the following blood thinner medications for seven (7) days prior to procedure.**

| | | | |
|---|---|---|---|
| Heparin | Effient | Ticlid (ticlopidine) | Pletal (cilostazol) |
| Aggrenox (ASA/Dipyridamole) | Lovenox (enoxparin) | Persantine (dipyridamole) | Plavix (clopidogrel) |

***DO NOT *take Coumadin five (5) days prior to the procedure.* ***

***If you take diabetic medications, please contact your physician to obtain medication instructions for the day of your bowel prep and day of your procedure.***

***Day of Procedure***

1. **Nothing to eat or drink after midnight (includes gum, mints and candy).**
2. **DO** take heart and blood pressure medication with a small sip of water.
3. You **MUST** have someone with you to drive you home after your procedure as the medications used during the procedure will make you drowsy.
4. Please shower the morning of your procedure and wear loose, comfortable clothing.
5. Do not wear perfume or cologne. But deodorant is fine.
6. Expect to be here 2 to 4 hours for your procedure and recovery time.
7. If you have questions, please contact your primary care physician.

***Please note:*** *You will be contacted by the Surgery Center the week prior to your procedure. They will go over your medications and final instructions for your procedure.*

Derby Ambulatory Surgery Center
1101 N. Rock Rd, Building 2
Derby, Kansas 67037
Phone 316-771-9999
Fax 316-771-4689

Dear Patient,

You will find enclosed paperwork regarding information on your procedure, Rights & Responsibilities and the Financial Policy. Please review and sign forms upon receipt, and send back to our facility. You may hand deliver, mail at the above address or fax the forms to (316) 771-4689. These forms must be received before your procedure. If you have any questions, please call (316) 771-9999.

Thank you,
The Staff at Derby Ambulatory Surgery Center

# Derby Ambulatory Surgery Center
# HEALTH HISTORY
## Have you had or do you still have any of the following?

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Hay fever/Sinusitis | | | Hiatal hernia/Acid reflux/ulcers | | |
| Recent cold/respiratory illness/Bronchitis | | | Females: Hysterectomy | | |
| Recent Pneumonia | | | Females: LMP_____ (first day of last menstral period) | | |
| **ASTHMA** | | | Diagnosed with **MRSA** or have open or non-healing wounds (methicillin resistant staph aureus) | | |
| Emphysema | | | | | |
| Sleep Apnea | | | | | |
| Do you smoke? How much?_____ | | | Eye muscle abnormalities | | |
| | | | Auto-immune diseases | | |
| **HIGH BLOOD PRESSURE** | | | Recent or current infection | | |
| Chest pain/angina | | | **Patient history or family history of Malignant Hyperthermia** | | |
| Heart murmur/mitral valve prolapse | | | | | |
| **HEART ATTACK** | | | Any family members with difficulty or unusual reactions to anesthesia | | |
| Vascular stints in any major vessel | | | | | |
| Congestive heart failure | | | History of post-op nausea/vomiting | | |
| Any other heart problem | | | Any other medical problems or health issues we need to be aware of:_____ _____ | | |
| Any physical, mental, or emotional limitations | | | | | |
| Bleeding or clotting disorders | | | Living Will or Advanced Directives | | |
| **SEIZURES/EPILEPSY** | | | Prosthetics/Orthopedic implants | | |
| Stroke/Polio/Paralysis | | | Body piercings/where?_____ | | |
| Tremors/Parkinsons | | | Hearing Aids | | |
| HIV/AIDS | | | Glasses/Contacts (circle) | | |
| Hepatitis A, B, or C | | | Braces, bridges, caps, crowns dentures, retainers (circle) | | |
| Blood transfusion | | | | | |
| Nasal, facial, head, neck, or back injuries | | | Do you chew tobacco? | | |
| | | | Do you drink alcohol? How much?_____ | | |
| **DIABETES (Last BS_____)** | | | | | |
| Thyroid/kidney/bladder problems | | | Do you use street drugs? Frequency_____ | | |
| Hepatitis/Jaundice/Liver Problems | | | | | |

**PLEASE ATTACH A LIST OF MEDICATIONS: INCLUDE DOSAGE AND FREQUENCY**

| ALLERGIES/REACTION | PREVIOUS SURGERIES |
|---|---|
| | |
| | |
| | |
| | |
| | |
| **LATEX ALLERGY? YES/NO (circle)** | |
| **REACTION?_____** | |

**PATIENT SIGNATURE**_____

☐ Reviewed

**RN SIGNATURE**_____ **DATE**_____

Family
MedCenters, PA
*AMBULATORY SURGERY CENTER*

PATIENT NAME: _____ SEX: M / F
LAST FIRST M.I.

SOCIAL SEC#: _____ DATE OF BIRTH: ___/___/___ AGE:_____

ADDRESS:_____
STREET CITY STATE ZIP

PRIMARY DR: _____ DR SEEN:_____

MARITAL STATUS: SINGLE / DIVORCED / MARRIED / WIDOW / WIDOWER

HOME PHONE (___) _____

WORK PHONE: (___) _____ CELL PHONE (___)_____

## CONTACTS

NAME/RELATIONSHIP TO PATIENT ADDRESS PHONE

## PRIMARY INSURANCE

EFF.DATE POLICY NO. INSURED NAME INSURANCE PLAN NAME GROUP#

## SECONDARY INSURANCE

EFF DATE POLICY NO. INSURED NAME INSURANCE PLAN NAME GROUP#

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination for the Medicare/Other Insurance company.

**SIGNATURE:** _____ **DATE:**_____

DERBY AMBULATORY SURGERY CENTER
1101 N. ROCK RD, BLDG 2
DERBY, KS 67037

YOU MUST SIGN AND BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE. IF YOU DO NOT, YOUR PROCEDURE WILL BE CANCELLED.

I acknowledge that I have received on a date in advance of my procedure date written and verbal information regarding the following items.

1. Patient Rights and Responsiblities
2. Policy on Advance Directives
3. Grievance Process
4. Physician Owners

Signature _____Date_____

**DERBY AMBULATORY SURGERY CENTER**
**1101 N. Rock Rd, Bldg 2, Derby, KS 67037**
**316-771-9999 316-771-4689 (fax)**

# Patient Rights and Responsibilities

## PATIENT RIGHTS:

The basic rights of human beings are of great importance.

1. The right to impartial access to treatment or accommodations that is available or medically indicated.
2. The right for independent expression.
3. The right for independent decision and action.
4. The right for independent personal dignity.
5. The concern for personal relationships.

During sickness, no matter how minor it may seem to medical and nursing staff, the absence or presence of these factors are of vital importance and may become the deciding factor in the survival or recovery of the patient. It is the facility's primary responsibility to assure that these factors are preserved for their patients.

The following basic, rights and responsibilities of patients are considered reasonably applicable to all hospitals and surgery centers. The patient may exercise his rights without being subject to discrimination or reprisal.

### Access to Care

Patients shall be accorded impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, religion, or sources of payment for care.

### Respect and Dignity

The patient has the right of considerate, respectful care at all times and under all circumstances, with recognition of his personal dignity. The patient has the right to be free from mental and physical abuse. Should this right be violated, the facility must notify the Kansas Department of Health and Environment within five (5) business days and the Kansas Department of Health and Environment immediately.

### Privacy and Confidentiality

The patient has the right, within the law, to personal and informational privacy, as manifested by the right to:

- Refuse to talk with or see anyone not officially connected with the facility, including visitors, or persons officially connected with the facility but who are not directly involved in their care.
- Wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
- Be interviewed and examined in surrounding designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional to the opposite sex, and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
- Expect that any discussion or consultation involving their case will be conducted discreetly, and that individuals not directly involved in their care will not be present without his/her permission.
- Have their record kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker.
- Have their medical record read only by individuals directly involved in their treatment or the monitoring of its quality, and by other individuals only on their written authorization or that of their legally authorized representative.
- Expect all communications and other records pertaining to their care, including the source of payment for treatment to be treated as confidential. Be placed in protective privacy when considered necessary for personal safety.

### Identity

The patient has the right to know the identity and professional status of individuals providing service to him/her, and to know which physicians or other practitioner is primarily responsible for their care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him/her, as well as the relationship to any other healthcare or educational institutions involved in their care. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

### Information

The patient has the right to obtain from the practitioner responsible for coordinating their care, complete and current information concerning their diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

Derby Ambulatory Surgery Center acknowledges that some or all of the physicians of Family Med Centers, P.A. have an investment interest at the surgery center.

### Communication

The patient has the right of access to people outside the facility by means of visitors, and by verbal and written communication.

**DERBY AMBULATORY SURGERY CENTER**
**1101 N. Rock Rd, Bldg 2, Derby, KS 67037**
**316-771-9999 316-771-4689 (fax)**

# Patient Rights and Responsibilities

### Consent

The patient has the right to be involved in the decision making of all aspects of their care. The patient has the right to reasonably informed participation in decisions involving their healthcare. To the degree possible, this should be based on a clear, concise explanation of his condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his/her voluntary, competent, and understanding consent, or that of their legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient has the right to know who is responsible for authorizing and performing the procedure or treatment.

The patient shall be informed if the facility proposes to engage in or perform human experimentation or other research/educational projects affecting their care or treatment, and the patient has the right to refuse to participate in any such activity.

### Pain

The patient has the right to have appropriate assessment and management of pain.

### Consultation

The patient, at his/her own expense, has the right to consult with a specialist.

### Refusal of Treatment

The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient of his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

A patient has the right to change primary or specialty physicians if other qualified physicians are available.

### Transfer and Continuity of Care

A patient may be transferred to another facility if the need for the transfer arrises. We have transfer agreements with Wesley Medical Center and Via Christi Regional Medical Center. The patient has the right to be informed by the responsible practitioner or their delegate of any continuing health care requirements following discharge from the facility.

### Personal Safety

The patient has the right to expect reasonable safety insofar as the facility practices and environment are concerned.

### Facility Charges

Regardless of the source of payment for his/her care, the patient has the right to request and receive an explanation of their total bill for services rendered in the facility. The patient has the right to timely notice prior to termination of his/her eligibility for reimbursement by any third party for the cost of their care.

### Facility Rules and Regulations

The patient should be informed of the facility rules and regulations applicable to their conduct as a patient. Patients are entitled to information about the facility's mechanisms for the initiation, review, and resolution of patient complaints.

## PATIENT'S RESPONSIBILITIES:

### Provision of Information

A patient has the responsibility to provide, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health. They have the responsibility to report unexpected changes in their condition(s) to the responsible practitioner. A patient is responsible for making it known whether they clearly comprehend a contemplated course of action and what is expected of them.

### Compliance with Instructions

A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for their care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioners orders, and as they enforce the applicable facility rules and regulations. The patient is responsible for keeping appointments and, when is unable to do so for any reason, for notifying the practitioner or the facility.

### Refusal of Treatment

The patient is responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.

**DERBY AMBULATORY SURGERY CENTER**
**1101 N. Rock Rd, Bldg 2, Derby, KS 67037**
**316-771-9999 316-771-4689 (fax)**

## Patient Rights and Responsibilities

**Facility Charges**

The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.

**Facility Rules and Regulations**

The patient is responsible for following facility rules and regulations affecting patient care and conduct.

**Respect and Consideration**

The patient is responsible for being considerate of the rights of other patients and facility personnel and for assisting in the control of noise, smoking and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.

**ADVANCE DIRECTIVE NOTIFICATION:**

In the state of Kansas, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Derby Ambulatory Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, the Derby Ambulatory Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

## PATIENT COMPLAINT OR GRIEVANCE

Patient complaints or grievances may be filed through the Derby Ambulatory Surgery Center (address is printed above) and/or the Kansas Department of Health and Environment.

Kansas Department of Health and Environment
Attn: Hospital Program
1000 SW Jackson, Suite 200
Topeka, Kansas 66612
800-842-0078 (in Kansas)
785-296-0131 (all other states)

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at: www.cms.hhs.gov/center/ombudsman.asp.

**The Governing Body of Derby Ambulatory Surgery Center**

Lorraine Alvarado, MD Lyle Brooks, MD Antonio Carro, MD Matthew Johnson, MD

David Kortje, MD David Niederee, MD Craig Parman, MD Del Rey, MD Ted Snodgrass, MD

Cynthia Ward, MD Greg Bongers, MD

**BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS**

_____ _____

**(Patient/Patient Representative Signature)** **(Print Name)**

**DATE:**_____