



Central Surgical Associates

1190 North State Street

Suite 502

Jackson, Ms. 39202

Tel. 601.944.1781

Fax: 601.353.0439

Visit our website: csurgical.com

Thank you for allowing us to participate in your colorectal health. We will be happy to schedule your Colonoscopy and EGD, but, first, we need you to fill out a packet and returned to our office. Once we receive this, we will be calling to set up a time and date for the procedure.

If you do not understand any of this information or have any questions please call Cameron at 601.944.1781 Ext. 770

PLEASE SEND COMPLETED FORMS AND COPY OF YOUR INSURANCE CARDS (FRONT AND BACK)



Colonoscopy & EGD Form

Referring Doctors: _____

Clinic Name _____

Patient Name: _____

Date of Birth: _____

Address: _____

Preferred Phone Number: _____

Insurance: _____

(Please Submit Copy of Card(s) with this Form)

HEART PROBLEMS (please list)

CARDIOLOGIST?

Name: _____ Phone: _____

Are you taking Blood Thinners or Aspirin?

Please list: _____

Please Circle Procedure we will be scheduling: Colonoscopy or EGD

HAVE YOU HAD A COLONOSCOPY BEFORE? YES ___ NO ___

IF YES, WHEN _____ WHERE _____

DOCTOR _____



CHECK HERE IF PATIENT HAS **NO SIGNS OR SYMPTOMS OF COLON DISEASE**

Please circle any that apply:

Parent, sibling or child with colon cancer

Parent, sibling or child with colon polyps

Personal history of Colon Cancer

Personal history of Crohns or Ulcerative Colitis

Personal history of polyps

CIRCLE ALL THAT APPLY:

BLOOD IN STOOL

SIGNIFICANT DIARRHEA

NAUSEA/ VOMITING

ABDOMINAL PAIN: Right Upper / Right Lower / Left Upper / Left Lower

UNEXPLAINED ANEMIA

ACID REFLUX

UNEXPLAINED WEIGHT LOSS

OTHER GI COMPLAINTS:



Patient Information

Patient Name _____
LAST First Middle

Date of Birth _____ Age _____ Sex () Male () Female

Social Security _____ () Married () Single () Divorce () Separated () Widowed

Please use your physical mailing address

Patient Mailing Address: _____ Apt: _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Patient Employment _____ Business Phone _____

Patient Email Address _____

Spouse Name _____ Spouse Date of Birth _____
Last First Middle

Spouse Social Security # _____

Spouse Employment _____ Spouse Employment Phone _____

Primary Health Insurance Company _____

Policy Number _____ Group Number _____

Primary Policy Holder _____ Date of Birth _____
Last First Middle

Secondary Health Insurance _____

Policy Number _____ Group Number _____

Primary Policy Holder _____ Date of Birth _____
Last First Middle

Name of person responsible for this account: _____

Relationship to patient _____

Contact # _____ DOB _____ SS# _____

Address _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work _____ Cell _____

Please Check Ethnicity Information

| | | | | | |
|--------------------------------|--|---------------------|--|----------|--|
| Black or African American | | Hispanic/ Latino | | English | |
| White | | Non-Hispanic/Latino | | French | |
| American Indian Alaska Native | | Refuse to Report | | German | |
| Native Hawaiian/Pacific Island | | | | Japanese | |
| Other | | | | Spanish | |

Billing and Insurance Claims:

- IT IS THE PATIENT’S RESPONSIBILITY TO NOTIFY US OF ANY INSURANCE REQUIREMENTS: PRE-CERT, SECOND OPINION, REFERRAL NUMBERS, CO-PAYS, X-RAYS, LAB PREFERENCE OR HOSPITAL PREFERENCE PER YOUR INSURANCE CARRIER.
- DENIAL OF CLAIMS OR UNPAID BILLS DUE TO INCORRECT INFORMATION WILL BE THE PATIENTS RESPONSIBILITY.

CENTRAL SURGICAL ASSOCIATES, PLLC CANNOT AND WILL NOT CHANGE PHYSICIAN DIAGNOSIS TO COVER NON-COVERED SERVICES. IF YOU FEEL THERE IS AN ERROR IN YOUR MEDICAL RECORD YOU MAY PUT IN A REQUEST AND OUR MEDICAL RECORDS DEPARTMENT WILL LOOK AT IT AND DETERMINE IF YOUR REQUEST IS VALID.

PATIENT/GUARDIAN BY SIGNING BELOW YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS UN-MET DEDUCTIBLES AND ANY UN-PAID PORTION OF THE BILL.

Disability/FMLA Forms:

- I UNDERSTAND THAT ANY ADDITIONAL CLAIM FORMS SUCH AS ATTENDING PHYSICIAN STATEMENTS OR DISABILITY FORMS THAT CENTRAL SURGICAL ASSOCIATES, PLLC FILLS OUT FOR ME, WILL ONLY BE FILLED OUT ON FRIDAYS AND I WILL BE CHARGED \$ 10.00 PER FORM DUE WHEN FORMS ARE PICKED UP, MAILED OR FAXED.
- FAMILY MEDICAL LEAVE (FMLA) FORMS ARE FILLED OUT AT A NO CHARGE TO THE PATIENT AND WILL BE FILLED OUT ON FRIDAY’S ONLY.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

BY SIGNING THIS FORM, I AUTHORIZE:

- CENTRAL SURGICAL ASSOCIATES, PLLC, NURSE, PHYSICIAN OR PHYSICIAN ASSISTANT TO TREAT ME.
- I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF-- (TPO) TREATMENT, PAYMENT OR OPERATIONS.
- I AUTHORIZE PAYMENT DIRECTLY TO CENTRAL SURGICAL ASSOCIATES, PLLC AND THE TREATING PHYSICIAN FOR ALL MEDICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.
- I UNDERSTAND THAT WHILE I AM UNDER CENTRAL SURGICAL ASSOCIATES, PLLC/PHYSICIAN TREATMENT IT IS ALSO MY RESPONSIBILITY TO NOTIFY CENTRAL SURGICAL ASSOCIATES, PLLC OF ANY CHANGES. SUCH AS ADDRESS CHANGE, PHONE NUMBER, INSURANCE, JOB, OR MARITAL STATUS. IT IS ALSO MY RESPONSIBILITY TO MAKE SURE CENTRAL SURGICAL ASSOCIATES; PLLC HAS A CORRECT COPY OF MY INSURANCE CARD(S).

CENTRAL SURGICAL ASSOCIATES, PLLC WILL FILE YOUR INSURANCE CLAIM FOR YOU. HOWEVER, YOU ARE RESPONSIBLE FOR MAKING SURE CLAIMS ARE PAID. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITIES.

Patient/Guardian

Signature:_____Relationship:_____

Date:_____



Dear Patient,

The next form for you to sign is called an arbitration agreement. This form states that if you are unhappy with our services and want to file a lawsuit, you will agree to go in front of an arbitrator instead of a twelve-person jury trial. You are not waving your rights to file a lawsuit. An arbitrator is a retired lawyer or judge. A law firm in another state chooses this person, so the person is not partial to either party. Our clinic does require you to sign this before you meet with the physician for an office visit or procedure. If you want to make any changes to this form, the physician will review it and will decide on treatment. If you refuse to sign this form our clinic will be happy to refer you to another physician or back to the physician that referred, you to our clinic. Please carefully read the arbitration agreement and if you still have any questions call our office at 601.944.1781. Please sign the highlighted areas and initial the highlighted boxes on the back of the arbitration.

Thank you,

Central Surgical Associates, PLLC

CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

_____, ("Patient") engages Central Surgical Associates, PLLC, or employee(s) thereof ("Clinic"), J. Russell Rooks, M.D., PLLC, H. Gregory Fiser, M.D. PLLC, Lee M. Nicols, M.D., PLLC, T. Matthew Jones, M.D., PLLC, Kara S. Logan, M.D., PLLC, Brian S. Hamilton, MD, PLLC, Courtney C. Wright, PA-C, Tammy Sims Davis, PA-C, Heather G. Morris, PA-C, Mackenzie Carmody, PA-C And associated Physicians/PA's, member(s) or employee(s) thereof ("Members"), and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative(s) of Patient, as the case may be, and the Clinic, the Members, and each Physician individually, where the claim or the amount in controversy exceeds \$5,000, such dispute or controversy shall be submitted to JAMS, or its successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of \$5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by the court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than \$125.00, with Clinic or Members bearing the other arbitration costs.

If you are not willing to submit to binding arbitration, the Clinic may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

Witness our signatures this the _____ day of _____, 20_____.

CENTRAL SURGICAL ASSOCIATES, PLLC
H. GREGORY FISER, M.D., PLLC
BRIAN S. HAMILTON, M.D., PLLC
T. MATTHEW JONES, M.D., PLLC
KARA S. LOGAN, M.D., PLLC
LEE M. NICOLS, M.D., PLLC
J. RUSSELL ROOKS, M.D., PLLC
Tammy Sims Davis, PA-C
Heather G. Morris, PA-C
Courtney C. Wright, PA-C
E. Mackenzie Carmody, PA-C
and associated Physicians/PA's

By: _____
Authorized Representative (Clinic)

By: _____
Patient

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic, the Members, and their employees and Physicians from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

By: _____
Parent or Guardian

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

Physician Initials

SUMMARY OF ARBITRATION AGREEMENT PATIENT: _____

| | | Patient's Initials In Each Box |
|-----|--|--------------------------------|
| 1. | Before signing the Agreement the Patient may make written changes in the Agreement if they so desire and present these to the Clinic for approval. | |
| 2. | The Patient is agreeing to arbitrate any disputes above \$5,000. You are agreeing not to sue the Clinic, its Members, or any of their Physicians or employees in a court of law. | |
| 3. | The Patient is waiving his or her constitutional or statutory right to a jury trial. | |
| 4. | Arbitration will be performed by JAMS. This is a national association of neutral arbitrators. They don't work for the Clinic, Physician(s), or for the Patient. The Clinic or the Members will pay the costs, except for the first \$125.00, and each side will pay for their own attorneys and other costs. | |
| 5. | This Agreement is effective to the date of this Agreement. | |
| 6. | The Patient can rescind this Agreement within 15 days, but must still arbitrate any claim arising before the Agreement is rescinded. | |
| 7. | If the Patient does not agree to arbitrate, or if you rescind this Agreement, the Clinic will either treat the Patient or immediately refer them to another doctor or group who can provide the medical care they need. The Patient is not in need of emergency care or under immediate stress. | |
| 8. | If a court rules that a dispute must be litigated and not arbitrated, any lawsuit must be filed in the county where services are rendered. | |
| 9. | In arbitration, each side will have a fair opportunity to present their evidence, but court rules do not necessarily apply. There is no appeal except in limited circumstances. | |
| 10. | Patient, Physician(s), Members and the Clinic all have the right to terminate their relationship at any time. | |
| 11. | A claim by you or the Physician(s), Members, or Clinic will be waived and forever barred if, on the date of the demand for arbitration, the claim would be barred by the applicable statute of limitations. | |
| 12. | If you still have any questions, you should consult an attorney before signing. | |

I hereby confirm that I have explained the Agreement to the Patient, and the Patient has affirmed his or her understanding of the Agreement by initialing or signing beside each of the foregoing provisions.

CENTRAL SURGICAL ASSOCIATES, PLLC Tammy Sims Davis, PA-C
H. GREGORY FISER, M.D., PLLC Heather G. Morris, PA-C
BRIAN S. HAMILTON, M.D., PLLC Courtney C. Wright, PA-C
T. MATTHEW JONES, M.D., PLLC E.Mackenzie Carmody, PA-C
KARA S. LOGAN, M.D., PLLC and associated Physicians/PA's
LEE M. NICOLS, M.D., PLLC
J. RUSSELL ROOKS, M.D., PLLC

By: _____
Authorized Representative (Clinic)

Physician Initials

PATIENT PORTAL AUTHORIZATION FORM

Our patient portal lets established patients communicate more easily with us. The portal is not intended for 'Web Visits' or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The patient portal provides you with a much more seamless way to access your health information and contact our office.

Through the portal, you can:

- Request refills and appointments.
- Update your contact and insurance information.
- Check your medication list, medical history and your visits.
- Get your lab results quickly.
- Email us securely back and forth.
- Email billing questions.

We want your records to be complete and correct. Let us know if there's any problem with your records.

Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your username and password to avoid misuse.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll keep things brief and clear in the Portal. We appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

If we have troubles, abuse or "Spam," we may need to change policies, suspend accounts, or even terminate the use of the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues, or if you are experiencing an emergency, you should call dial 911 or go to the nearest Emergency Room.

By signing below and providing my **Email address**, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.

____ **YES, I wish to sign up for portal** ____ **No I DO NOT wish to sign up for Portal**

If yes, Email Address: _____

Signature: _____

HIPAA Information and Consent Form

2015 Patient Paperwork

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available upon your request.

There are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's, etc.) may be stored in file cabinets not accessible to patients. Preparing for and during your office visit, such records may be left, at least temporarily, in administrative areas such as the front office, doctor's desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following: e-mail, texting, and calling. We try to make every effort to remind you of your appointment and any treatment that you may need.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays if needed. We also send electronic claims to your health insurance, which includes submitting PHI to receive payment for services provided.

You permit us to remind you to take pre-medication before appointments, if applicable.

You give us permission to call in prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes some vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint

Your confidential information will not be used for marketing or advertising of products, goods or services without your permission

We agree to provide patients with access to their records by state and federal laws. We may update this policy as needed to serve the needs of our patients and our practice.

By signing below, I agree that I have been offered and will receive a full version of the HIPAA policy upon my request. I understand and acknowledge my agreement to the terms outlined in the HIPAA information and consent form and any future updates to this policy.

Signature: _____

❖ Patient Name: _____

Please Circle:

Which physician are you seeing today: Fiser Jones Logan Nicols Rooks

Reason for visit: _____

Symptoms/Complaints: _____

How long have you had this complaint? _____

Referring Physician: _____ Family Physician: _____

PAST MEDICAL HISTORY (please check all that apply)

| | | | |
|-----------------|--|---------------------|--|
| Aids/HIV | | Hepatitis | |
| Asthma | | High Blood Pressure | |
| Blood Clots | | High Cholesterol | |
| COPD | | Kidney Disease | |
| Diabetes | | Jaundice | |
| Heart Attack | | Seizures | |
| Heart Disease | | Stroke | |
| Cancer (type): | | | |
| Year Diagnosed: | | | |
| Other: | | | |

| Tobacco | Never | Current | Former | Packs Per Day | # Years |
|------------|-------|---------|--------|---------------|---------|
| Cigarettes | | | | | |
| Smokeless | | | | | |

| Alcohol | Never | Occasional | Daily | Drinks per day |
|---------|-------|------------|-------|----------------|
| | | | | |

| Controlled Substances(Drugs) | Never | Occasional | Daily | Type Used |
|------------------------------|-------|------------|-------|-----------|
| | | | | |

Family History

| <u>Heart attack</u> | <u>Stroke</u> | <u>High Blood Pressure</u> | <u>Diabetes</u> | <u>Cancer</u> | <u>Type</u> |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|-------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Mother | <input type="checkbox"/> Mother | <input type="checkbox"/> Mother | <input type="checkbox"/> Mother | _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Father | <input type="checkbox"/> Father | <input type="checkbox"/> Father | <input type="checkbox"/> Father | _____ |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Brother | <input type="checkbox"/> Brother | <input type="checkbox"/> Brother | <input type="checkbox"/> Brother | _____ |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Sister | <input type="checkbox"/> Sister | <input type="checkbox"/> Sister | <input type="checkbox"/> Sister | _____ |
| Other: | | | | | |

❖ Patient Name: _____

SURGICAL HISTORY Please check all that apply and circle right or left as it applies.

| | | | |
|---------------------|--|---------------------------------------|--|
| Appendectomy | | Mastectomy Right or Left or Both | |
| Colon Surgery | | Lumpectomy Right or Left or Both | |
| Thyroid Removal | | Hemorrhoidectomy | |
| Heart Surgery | | Kidney Transplant | |
| Hysterectomy | | Hiatal Hernia Repair | |
| EGD (throat scope) | | Incisional Hernia Repair | |
| Colonoscopy | | Umbilical Hernia Repair | |
| Gastric Bypass | | Inguinal Hernia Repair R or L or Both | |
| Gallbladder Surgery | | Other: | |
| Prostate Surgery | | Other: | |

Pharmacy Information

| Preferred Pharmacy | Location | Phone |
|--------------------|----------|-------|
| | | |

List Medications “Currently Using” over the counter or prescribed

| Medication | Dose | Times per day | Medication | Dose | Times per day |
|------------|------|---------------|------------|------|---------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Use back page if you need more space

Medication Allergies:

| | | | |
|-------------|--|---------------------|--|
| Penicillin | | Lidocaine | |
| Cipro | | General Anesthesia | |
| Bactrim | | IVP DYE (X-ray dye) | |
| Doxycycline | | Silver Products | |
| Clindamycin | | Sulfa | |

Please list any other allergies:

❖ Patient Name: _____

Have you had a mammogram within the last year?

No

Yes, Date: _____ Location: _____

Do you see a Cardiologist (heart doctor)? If so, Dr _____

Do you see a Pulmonologist (lung doctor)? If so, Dr _____

Dialysis Patients Only

Days you dialyze: Monday/Wednesday/Friday Tuesday/Thursday/Saturday

Dialysis Unit Name/Location: _____

Dialysis Time: _____ Unit Phone #: _____

Workman's Compensation Only

Are you being seen for a work-related accident? YES NO

Have you reported the accident/injury to Workman's Compensation? YES NO

Date of accident/injury: _____

Describe accident/injury: _____

I authorize Central Surgical Associates, PLLC to discuss my medical conditions and care with the following person(s):

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Do you have a person who can make medical decisions on your behalf if you are unable to?

YES

NO

If so, Name: _____ Relationship: _____

Please rate your pain using the chart below

Wong-Baker FACES® Pain Rating Scale





Consent for EGD/Colonoscopy

This is to authorize the performance of the above procedure and/or surgical intervention upon _____. This procedure is to be performed by, or under the direction of, Dr. _____ and/or such associates and assistants designated by the physician.

Diagnosis:

- You have been diagnosed with: _____
- You are scheduled for a screening colonoscopy.

Name of Procedure/Treatment:

- EGD**: is an examination of the upper part of the digestive tract which is performed to find the cause of your symptoms. (Esophagogastroduodenoscopy) Or Upper endoscopy is a procedure in which a thin scope with a light and camera at its tip is passed through the mouth and down the throat. This is done to look inside the upper digestive is used to look inside the upper digestive tract -- the [esophagus](#), [stomach](#), and first part of the small intestine called the duodenum A thin, flexible tube called and the endoscope is inserted through the mouth to look at the upper GI tract. **Bowel prep is not required for an EGD alone.**
- Colonoscopy**: is an examination of the lower part of the digestive tract which is performed to find the cause of symptoms or to screen for cancer. A thin, flexible tube called a colonoscope is inserted through the rectum to look at the colon. A small video camera is attached to the colonoscope so that your doctor can take pictures or video of the large intestine (colon). Before this test, you will need to clean out your colon. **The colon prep instructions are located at the end of this consent form.**
- Esophageal Dilatation**- is a procedure that allows your doctor to dilate, or stretch, a narrowed area of your ***esophagus (swallowing tube)***

If the physician during your exam sees a suspicious lesion, the following procedures may be performed.

- **Biopsy** - Taking a piece of mass or polyp (small clump of cells that forms on the lining of the colon) to send for further testing.
- **Polypectomy**- removal of polyp(s) (small clump of cells that forms on the lining of the colon)

Risks common to all surgical procedures:

- Injury to a blood vessel or excessive bleeding. This may require a blood transfusion.
- Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
- Complications with anesthesia. This may include nausea, vomiting, heart attack, stroke or, in rare cases, death.
- Tobacco use, excessive alcohol use, and obesity can increase the risk of any surgical procedure or general anesthetic. Any of these factors may substantially affect healing and can result in an increase of major complications including pneumonia, wound infection, blood clots in the legs and lungs, or death.

Risks and consequences of the proposed treatment:

- Injury to the colon or upper GI tract that could require that another surgical procedure is performed.
- Bleeding, should the colon or upper GI tract be injured
- Fissure (tear in the anus)
- Will not be able to find out what my medical problem is
- May miss seeing the cause of my problem
- Reactions or side effects of IV sedation (nausea, amnesia)

Risks or consequences of the proposed treatment that is specific and unique to the patient:

Diabetes Hypertension Obesity COPD NONE

Other: _____

Alternative treatments:

- Do nothing
- Medication treatments

Prognosis if the proposed treatment is NOT accepted:

- Continued or worsening symptoms
- The growth of cancer or the spread of cancer if present
- Bowel perforation (the hole that develops in the intestines)

**I received a copy of the prescribed bowel prep. _____(please initial)
Pages 4-6**

I understand the above information and give my consent to have the described procedure performed.

I authorize the performance of any extension of the procedure. I further authorize my physician to perform any procedures which may become necessary during my surgery.

I have had the opportunity to ask any questions about my physician/provider and have had all my questions answered to my satisfaction. No guarantees have been made to me regarding the success of this procedure to treat my condition.

Patient Signature

Date

Physician/Provider Signature

Date

If patient is unable to sign:

Print name of signee

Signature

Date

Description of Authority to Consent

(Ex. relationship to patient, Healthcare Power of Attorney, legal guardian, ward of the State of MS, etc.)

Signature of Witness (only required if patient is unable to sign)

Date

Patient Chart # _____

Created 2016



Gatorade / Miralax Prep for Colonoscopy

You need to buy the following (no prescriptions are needed):

1. **One 64 oz or two 32 oz bottles of Gatorade**, Propel, Crystal Lite or other noncarbonated clear liquid drink (**NO RED or PURPLE COLOR**). If you have diabetes, you may use sugar-free Gatorade. Refrigerate if you prefer to drink it cold.
2. **Dulcolax laxative tablets** (not suppository or stool softener and you will need 4 tablets for the prep).
3. **Miralax 238 grams (8.3 ounces) powder** or generic polyethylene glycol 3350 (can find in laxative section)
4. **One bottle of Magnesium Citrate**

One Week Prior to Your Procedure:

1. Discontinue fiber supplements: Metamucil, Citrucel, Fibercon, etc....
2. Discontinue taking iron pills or medications that can cause bleeding (Alleve, naprosyn, Motrin, ibuprofen, sulindac, or any other NSAID). Use Tylenol for pain if needed.
3. Discontinue Plavix / Aggrenox/Coumadin – check with your cardiologist or prescribing physician prior to stopping (cardiac clearance may be needed)
4. If you are on aspirin because of a history of stroke or heart disease then continue aspirin; otherwise stop it.
5. Discontinue all over the counter herbal products / Vitamin E.

Five days prior to your procedure: stop Coumadin – we will check with your cardiologist or prescribing physician prior to stopping (cardiac clearance may be needed).

Two days prior to your procedure:

Drink one bottle of Magnesium Citrate at 6:00PM after Dinner

Being a Low residue diet

Allowed: soup, fish, chicken, eggs, white rice, bread, crackers, plain yogurt, pasta, potato with no skin, gelatin, broth, bouillon, all liquids

Avoid: fresh and dried fruit, all vegetables, raisins, dried fruits, nuts, seeds, cloves, any other meat besides what is listed above

One day before the colonoscopy: this is the prep day, only clear liquids are allowed until the procedure is completed. Consumption of anything other than clear liquids will impair the quality of the prep, thus, impairing the quality and safety of the colonoscopy. You may have clear liquids up until 6 hours prior to your procedure. Nothing by mouth for 6 hours prior to the procedure unless directed to do so.

Allowed: Clear liquid diet is liquid food that you can see through. This includes water, fruit juices, jello, (NO RED COLOR or PURPLE) clear broth or bouillon, clear fluids (Sprite, sports drinks, etc...), popsicles, etc. Please consume plenty of clear liquids! A colonoscopy prep can cause dehydration and loss of electrolytes if you do not!

Avoid: All solids foods, milk and milk products, and any item with red dye. Limit coffee and tea as they can dehydrate you.

One day before the colonoscopy: begin the colon prep as detailed below.

- 1) In the morning, in a pitcher mix the 8.3 oz of Miralax with the 64 oz of Gatorade. Stir / shake the contents until entire contents of Miralax are completely dissolved. Chill if desired
- 2) At 3PM take 4 tablets of dulcolax laxative pill with water by mouth.
- 3) At 5 PM drink one 8 ounce glass every 15 minutes till finished with all of the solution.
- 4) Continue drinking clear fluids until bedtime.

Day of procedure:

- 1) If you take blood pressure or heart medicine you may take it with a sip of water.
- 2) You can have clear liquids up until 6 hours prior to the scheduled procedure time.
- 3) Wear loose clothing and leave your jewelry and valuables at home.
- 4) Bring a list of all your medications to the center.
- 5) We generally run on schedule so please arrive on time. Occasionally an unforeseen event may cause us to be delayed. Please bring some material to keep you occupied if one of these rare events occur.
- 6) **YOU MUST HAVE A RIDE AFTER THE PROCEDURE!** A responsible adult must take you home. Going in a taxi or bus by yourself will not be allowed.

If you are diabetic:

- 1) Use sugar-free drinks during the prep and monitor your blood sugar closely to prevent low blood sugar and use insulin sliding scale if needed for high values
- 2) If you are on insulin take half of your usual evening dose the day prior to the procedure and also on the morning of the procedure.
- 3) Hold your diabetic medication the morning of the test if you are not on insulin.
- 4) Bring candy with you in the event your blood sugar drops while you are awaiting your procedure.

Helpful tips:

- 1) Some people may develop nausea with vomiting during the prep. The best remedy for this is to take a break from drinking the solution for about 30 minutes and then resume drinking at a slower rate. It is important to drink the entire contents of the solution.
- 2) Walking between drinking each glass can help with bloating.
- 3) Use baby wipes instead of toilet paper.
- 4) Apply some Vaseline or Desitin to the anal area / between buttocks prior to beginning the prep and reapply as needed.
- 5) Remain close to toilet facilities as multiple bowel movements may occur. This prep often works within 30 minutes but may take as long as three hours.

RESULTS AND FOLLOW-UP

Results will be given both verbally and in written form right after the procedure. They will be discussed with you and anyone waiting for you if you so direct. We will contact you by phone if anything needs immediate follow-up. **If you have not heard anything by 2 weeks then contact the office for results.**

Office follow-up is usually not necessary after a routine colonoscopy. Your next recommended colonoscopy is usually based on family history, findings at the time of colonoscopy, pathology results or other risk factors.

INSURANCE

Colonoscopies are frequently covered by insurance companies. You may still be responsible for a deductible or a co-payment. While our office will generally pre-certify your procedure, **IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS FOR THIS PROCEDURE.** Medicare does not require precertification.