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 to have an updated medical history filled out and returned to our office. We have provided a self-addressed envelope for your convenience. 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 at 601.944.1781 Ext. 785 leave a detailed Voicemail with your Name, Return Phone Number, and Date of Birth.

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

CENTRAL SURGICAL ASSOCIATES, PLLC

Colonoscopy & EGD Form

Patient Name: _____ _____

Date of Birth:_____Preferred Phone #:_____

Address: _____ _____

City:_____State:_____Zip:_____

Preferred Phone Number:

Insurance: 1.

Insurance: 2._____

Please send a copy of your insurance card(s) front and back with this form.

Referring Physician:_____

Clinic Name and Location:_____

HEART PROBLEMS (please list)

Do you have a CARDIOLOGIST?

Dr. Phone:

Are you taking Blood Thinners or Aspirin? ____Yes ____No

Please list:

Please Circle Procedure we will be scheduling: Colonoscopy or EGD

HAVE YOU HAD A COLONOSCOPY BEFORE? ____YES_____NO

IF YES, WHEN_____WHERE _____

Who did your last Colonoscopy? _____

CENTRAL SURGICAL ASSOCIATES, PLLC

*PATIENT NAME:*_____*DATE OF BIRTH:* _____

_____*IF THE PATIENT HAS NO SIGNS OR SYMPTOMS OF COLON DISEASE, PLEASE CHECK HERE.*

Please check any that apply.

___Parent____sibling or____child **with colon cancer**

___Parent____sibling or____child **with colon polyps**

Please check any of the following that apply to you.

___Personal history of Colon Cancer
___Personal history of Crohns
___Personal History of Ulcerative Colitis
___Personal history of polyps

Please check any of the following that apply to you.

____BLOOD IN STOOL
____SIGNIFICANT DIARRHEA
____NAUSEA/ VOMITING
____UNEXPLAINED ANEMIA
____ACID REFLUX
____UNEXPLAINED WEIGHT LOSS
____NONE OF THE ABOVE
____OTHER_____

DO YOU HAVE ABDOMINAL PAIN:____YES____NO

IF SO,WHERE IS IT LOCATED?

Please check location:____Right Upper___Right Lower___Left Upper___Left Lower

ANY 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_____

Pharmacy Information

Preferred Pharmacy:_____Location:_____Phone:_____

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 PATIENT'S 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 YOU 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 following 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 waiving your rights to file a lawsuit. An arbitrator is a retired lawyer or judge, and 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 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, M.D., 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. This agreement further applies to any claim that derives or arises from a claim that the Patient or someone on a Patient's behalf asserts against the Clinic or any of its Members or employees. 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 arbitration in the Jackson metropolitan area pursuant to 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 any 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.

The arbitration proceedings or any award or judgment arising therefrom shall be confidential. Should the award need to be filed with a court for confirmation or enforcement purposes, the award shall be filed under seal and will remain under seal unless not satisfied within twenty (20) days of the later of the filing of the Motion to Confirm the Award or the conclusion of any appeal taken by agreement of the parties pursuant to JAMS Optional Arbitration Appeal Procedure, if applicable.

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 Circuit Court of Rankin County, Mississippi.

This agreement is binding upon spouses, heirs, administrators, executors, personal representatives, successors, and assigns and the undersigned's spouse (if any) acknowledges this. A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

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
Holly Rosamond, FNP-C
and associated Physicians/PA's/NP'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

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 consideration.	
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.	This agreement is binding on the patient's spouse, heirs, administrators, executors, personal representatives, successors, and assigns. It applies to any claim that derives or arises from care provided to the patient.	
4.	The Patient is waiving his or her constitutional or statutory right to a jury trial.	
5.	Arbitration will be performed by JAMS. This is a national association of neutral arbitrators. They do not 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 litigation costs.	
6.	This Agreement is effective on the date of this Agreement and applies to all claims regardless of when the care at issue occurred.	
7.	The Patient can rescind this Agreement within 15 days but must still arbitrate any claim arising from care provided before the Agreement is rescinded.	
8.	If the Patient does not agree to arbitrate, or if this Agreement is rescinded, the Clinic will either treat the Patient or refer them to another doctor or group who can provide the medical care they need. The Patient acknowledges that (s)he is not in need of emergency care or under immediate stress.	
9.	If a court rules that a dispute must be litigated and not arbitrated, any lawsuit must be filed or tried in the Circuit Court of Rankin County, Mississippi.	
10.	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.	
11.	Patient, Physician(s), Members, and the Clinic all have the right to terminate their relationship at any time.	
12.	A claim by or on behalf of the Patient or the Physician(s), Members, or Clinic will be waived and forever barred if, on the date of the Notice of Intent or demand for arbitration, the claim would be barred by the applicable statute of limitations.	
13.	The arbitration proceedings and any award from such proceeding are confidential. Any award that is filed for confirmation must be filed under seal and shall remain confidential unless not timely satisfied as previously discussed.	
14.	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.

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E. Mackenzie Carmody, PA-C
Holly Rosamond, FNP-C
and associated Physicians/PA's/NP's

By: _____
Authorized Representative (Clinic)

_____
Physician's 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 <u>if you are experiencing an emergency, you should call dial 911 or go to the nearest Emergency Room.</u>

By signing below and providing my **<u>Email address.</u>** 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 HIPP*A* 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. HIP*AA* 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 HIPP*A* 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

Heart attack	Stroke	High Blood Pressure	Diabetes	Cancer	Type
☐Mother	☐Mother	☐Mother	☐Mother	☐Mother	_____
☐Father	☐Father	☐Father	☐Father	☐Father	_____
☐Brother	☐Brother	☐Brother	☐Brother	☐Brother	_____
☐Sister	☐Sister	☐Sister	☐Sister	☐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):

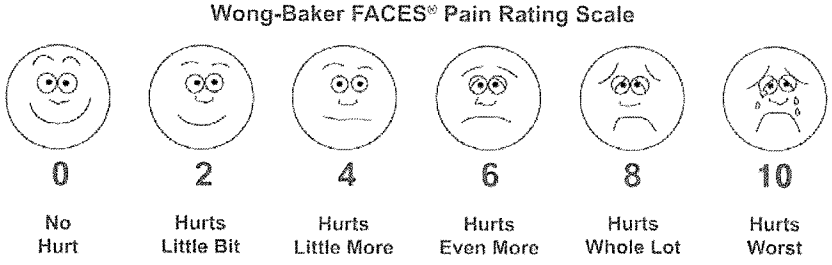
1. _____Relationship_____
2. _____Relationship_____
3. _____Relationship_____

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



Bowel Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Select all that apply.

- ☐ Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
- ☐ Bowel accidents while unaware—no warning and/or while asleep
- ☐ Frequent, loose, watery stools
- ☐ Sudden or strong urge to go to the bathroom
- ☐ Bowel accidents when passing gas
- ☐ No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Approximately how many bowel incidents do you have per week? _____

Have you tried medications to help your symptoms? ☐ Yes ☐ No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

No Relief ***Complete Symptom Relief***

Behavior modifications tried? _____

(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bowel medications?

☐ Yes ☐ No

UC20120178Oc EN

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

Surgical Deposit Policy

It is the policy of Central Surgical Associates, PLLC to collect a surgical deposit from all patients prior to any surgical procedure(s).

If your care requires you to have surgery, and you have insurance coverage, our staff will verify your insurance benefits with your insurance plan. If you have not met your deductible or you have a co-insurance, you will be required to provide a deposit on your account.

If you have no insurance coverage, a limited insurance policy, or a health share policy, you will be required to provide a deposit on your account.

It is the patient's responsibility to notify our office of any changes in insurance coverage. Failure to do so, will result in patient being responsible for denial of claims or unpaid bills.

Your deposit will be due no later than 3 business days prior to your scheduled surgery.

We offer several payment options for your convenience:

- Visa
- MasterCard
- Discover
- American Express
- Care Credit
- Cash
- Personal checks

Payments may be made in person, over the phone, or by going to our website at www.centralsurgicalassociates.com.

In an effort to keep our patients informed, the deposit you provide to our office is for services only rendered by the physicians and physician assistants at Central Surgical Associates.
You may be required to provide separate deposits for the facility and/or anesthesia.

I, _____, have read and fully understand that a surgical deposit is due no later than 3 business days prior to my scheduled date of surgery. I understand that I may be required to pay a separate deposit to the facility and/or anesthesia. **I also understand that if full payment of my surgical deposit is not received by the due date, my surgery may be cancelled without notice.**

Patient or Parent/Legal Guardian Signature _____ Date: _____
Central Surgical Employee Signature _____ Date: _____

CENTRAL SURGICAL

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 [illegible] other noncarbonated clear liquid drink **(NO RED or PURPLE COLO[illegible]** If you [illegible] diabetes, you may use sugar-free Gatorade. Refrigerate if you pre[illegible] to drink cold.
2. **Dulcolax laxative tablets** (not suppository or stool soft[illegible] and [illegible] 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, Fiber[illegible]n, etc....
2. Discontinue taking iron pills or medications that can cause bleeding Alleve, naprosyn, Motrin, ibuprofen, sulindac or any other NSAID[illegible] 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 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

Not allowed: 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 until 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 events occur.
6) **YOU MUST HAVE A RIDE AFTER THE PROCEDURE!** A responsible adult must take you home. Coming in a taxi or 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 in 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 occu[r]. 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 af[ter] the proc[edu]re. They w[ill] be discussed with you and anyone waiting for you if you so direc[t]. We will conta[ct] you by [pho]ne if anything needs immediate follow-up. **If you have not heard a[nyt]hing by 2 weeks t[hen] contact the office for results.**

Office follow-up is usually not necessary after a [rou]tine colonoscop[y]. [Your n]ext recommended colonoscopy is usually based on family histor[y] findings at the time of colonoscopy, pathology results or other risk factors.

INSURANCE

Colonoscopies are frequently [cov]ered by [ins]urance co[m]panies. You may still be responsible for a deductible [or] a c[o-pay]. [Wh]ile our office will generally pre-certify your procedure, IT IS YO[UR] RESPONS[IB]ILITY TO C[ONTACT] YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS [FO]R THIS PROCEDURE. Medicare d[oes] not [req]uire pre[-c]ertification.