



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. 788 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)



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? _____



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

PLEASE USE INK ONLY

NO PENCILS PLEASE

Patient Name _____

Date of Birth _____ 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 _____

Spouse Social Security # _____

Spouse Employment _____ Spouse Employment Phone _____

Primary Health Insurance Company _____

Policy Number _____ Group Number _____

Primary Policy Holder _____ Date of Birth _____

Secondary Health Insurance _____

Policy Number _____ Group Number _____

Primary Policy Holder _____ Date of Birth _____

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 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: _____

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

By: _____
Authorized Representative (Clinic)

Physician's Initials

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: _____

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.

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 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.

<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	-----------------------------

*Not
Frustrated*

*Very
Frustrated*

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

Yes No

Central Surgical Associates, PLLC Authorization for Release, Use, and Disclosure of Health Information

Date: _____

I. **PATIENT.** Patient's Name: _____ Date of Birth: _____

Social Security Number: _____

II. **AUTHORIZATION.** I authorize (select one):

Central Surgical Associates, PLLC to disclose my health information to the following:

Name: _____ Phone: _____

The following entity to disclose my health information to Central Surgical Associates, PLLC:

Name: _____ Phone: _____

Please select all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative and Procedure Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> X-ray and Imaging Results |
| <input type="checkbox"/> Pathology Results | <input type="checkbox"/> Clinical and Progress Notes | <input type="checkbox"/> Billing Records |

Other (list specific items): _____

Hereinafter known as "Medical Records".

III. **DELIVERY.** Please select one of the following:

I will pick up copies of my records

Fax my records to: _____

Mail copies of my records to the following: _____

IV. **PURPOSE.** The reason for this authorization is: (check one)

Personal Legal/Attorney Insurance Disability Continuing Care School Worker's Compensation

Other (be specific): _____

V. **SENSITIVE INFORMATION RELEASE**

I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of each initialed sensitive information item:

___ Substance Abuse Treatment Information ___ Mental Health Information ___ Genetic Testing

___ HIV related information (including AIDS related testing)

VI. **ACKNOWLEDGEMENT OF RIGHTS.**

I understand that unless the purpose of this authorization is to determine payment of a claim or benefits, Central Surgical Associates may not condition the provision of treatment or payment for my care on my signing this authorization. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. If you wish to take your permission away, please send a written notice with signature to Central Surgical Associates, PLLC 1190 North State Street, Suite 502, Jackson, MS 39202. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the Federal privacy regulations. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I understand that I am entitled to receive a copy of this form after I sign it. A copy of this authorization is as valid as the original.

VII. **SIGNATURE.**

I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". I acknowledge this authorization with my signature below.

Signature of Patient/Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

If the patient listed above is under the age of 18, this authorization form and any revocation must be signed by a parent, guardian, or other person who has the authority to act on the behalf of minor. As the person signing for the patient, I, the parent, guardian, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.

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: _____



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 for 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 an 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 be 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
- Growth of cancer or spread of cancer if present
- Bowel perforation (hole that develops in the intestines)

I received a copy of the prescribed bowel prep. _____ (please initial)

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 of 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 # _____