NORTH HILLS ENDOSCOPY CENTER

3344 N Futrall Drive
Fayetteville, AR 72703
(479) 582-7280

Michael L. Rogers, M.D.
Gary A. Thomas, M.D.
Chad E. Paschall, M.D.
Sidney L. Vinson, M.D.
John D. Moore, M.D.

The following instructions are to be followed so that you will have a clean bowel on the day of your colonoscopy. This is very important for an adequate examination.

The day before your exam you will be on a clear liquid diet. This consists of 7UP, coke, tea, broth, strained soup, coffee, juices such as orange, grape, apple, etc. Also, you may have Jell-O and popsicles but avoid cherry and strawberry because these have a red dye that will stain the colon. ****DO NOT CONSUME ANY SOLID FOODS OR MILK PRODUCTS THE DAY BEFORE OR THE DAY OF THE EXAMINATION.**** You may have clear liquids the morning of your procedure **up to 4 hours prior** to your arrival time.

This prep requires 3 over the counter ingredients:

1. Four 5mg **DULCOLAX** laxative tablets
2. **MIRALAX** powder -- 238 gram bottle
3. 64 oz of **G2 (the low calorie Gatorade)** or **Crystal Light**
4. One bottle of **Magnesium Citrate**

Directions for mixing prep: Mix the entire 238 gram bottle of Miralax with the G2 or Crystal Light in a large pitcher. Shake or stir until fully dissolved. Chill and add ice if you would like.

The day BEFORE your procedure--

*Beginning at **12:00 noon,** drink the bottle of Magnesium Citrate.

*Beginning at **2:00 pm**, start drinking your Miralax prep. Every 15-30 minutes, drink an 8 oz glass until you have finished the 64 oz.

*Beginning at **4:00 pm,** take all 4 Dulcolax tablets.

NOTICE TO PATIENT: One week before your scheduled procedure, please do not take any iron or iron supplements.

If you have any of the following conditions, please call our office to speak with a nurse prior to your appt.

- **If you are on Coumadin, Ticlid, Plavix, Lovenox, or any other prescribed blood thinners**
- **If you are diabetic** and you take **Insulin**, take ½ dose day before procedure, **NO** insulin day of procedure. If you take **Oral Diabetic Meds**, do not take the morning of only. Also, **make sure you have some liquids WITH sugar in them as well as sugar-free**
- **If you are allergic to latex**
- **If you have an internal defibrillator or prosthetic mitral valve**

Please **take all other medications** with a small sip of water the morning of your procedure.

It is our policy that you have an adult driver to take you home after the procedure. If you do not have a driver, your procedure will have to be canceled or done without sedation.
Out of courtesy to other patients waiting for appointment availability, please note that we have a 2 business day cancellation policy. All other cancellations/no shows may be subject to a $50 cancellation fee.

Please report to North Hills Endoscopy Center at 3344 N. Futrall Dr. North Hills Endoscopy Center is located inside the Fayetteville Diagnostic Clinic. If you have any questions, please feel free to call Christi at **(479) 582-7289**.

Your appointment is: DATE: ____________________ TIME: ______________

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MEDICAL PARK
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You have been scheduled to have a colonoscopy at North Hills Endoscopy Center. This is an exam that allows the doctor to examine the lining of the rectum and the large intestine (colon) and to identify any abnormalities.

Upon arrival, your insurance and billing information will be obtained. Please bring your insurance cards with you the day of your exam. A pager can be made available to your driver to allow them to run errands while waiting for your procedure to be completed. Plan on being at the center a total of 2-3 hours.

You will be checked in, weighed and asked to sign a consent form authorizing the doctor to perform the procedure. You will be asked several questions about your past medical and surgical history. We will then escort you to either the holding room or an exam room and an IV will be started. Medicine will be injected through this catheter to make you sleepy and relaxed just before the procedure begins.

As you lie on your left side, the doctor will insert the lubricated, flexible colonoscope. This will give you a mild sensation of wanting to move your bowels. You may feel some cramping or gas due to air, which the doctor is putting into the colon. You may be asked to change positions during the procedure to assist in passing the colonoscope.

Often, a biopsy (tiny bit of tissue) is taken for microscopic examination. You will not feel any sensation or discomfort when a biopsy is taken.

Many people do not recall any of the procedure because of the effect of the medicine. After the procedure, you will probably feel drowsy and may sleep for a short while. You may feel some bloating or nausea from the air inserted during the procedure.

Before you leave, the doctor will discuss the findings with you. **Please have your driver present at this time.** The nurse will give you written instructions to follow when you get home.

You may not drive or work the day of your procedure.

Plan on eating a light meal such as soup and crackers when you leave the center.

You may not have a bowel movement for three or four days following a colonoscopy. In addition, you may experience a small amount of blood in your stool. If you experience any excessive bleeding, pain or fever, please call the center.

If you have any questions, please call (479) 582-7280 to speak with a nurse.

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Dear Patient:

Your doctor has scheduled a procedure for you in our facility. Please complete the enclosed patient registration form and medication list to bring with you on the day of your procedure. Please bring your insurance cards and a photo ID such as your driver's license so that we may copy them for our files.

It is your responsibility to contact your insurance company to see if pre-certification is needed for your procedure. It is not necessary to notify Medicare of your scheduled procedure. Please tell the insurance company representative that your procedure will be performed as out-patient at North Hills Endoscopy Center. There should be a toll-free telephone number on your insurance card.

In addition to the billing from North Hills Endoscopy Center (**facility charge**), you will also incur a charge from the Fayetteville Diagnostic Clinic (**physician charge**). If biopsies are taken or if polyps are removed during the procedure, you will be billed separately from a local pathology office for that service.

The day of your procedure, you will be expected to pay the percentage that your insurance company does not pay plus any unpaid deductible. We offer Care Credit and can submit an application for balances due of $300 and above at your request. Care Credit offers an interest free credit plan if paid monthly and within the promotional period. If you wish to apply, please contact us prior to your procedure for this payment option.

If you have any questions, please call our patient account personnel at (479) 582-7280.

Sincerely,

Patient Accounts Department

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NAME:______________________________ PROCEDURE DATE:______________

We ask that you please fill out this form and bring it with you the day of your procedure, this will help us with the admitting process. If you already have a list of your current medications it won't be necessary to fill this form out, but be sure to bring your list with you.

Allergic to LATEX? YES NO

Allergic to Medication? YES NO

Please list____

Have you had any surgeries done? YES NO

Please list____

____

If you are taking any blood thinners be sure to stop those one week before your procedure.

Medication	Dose	Times per day	Date last taken	Medication	Dose	Times per day	Date last taken

Thank you for your cooperation and we will see you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

Exercise his or her rights without being subjected to discrimination or reprisal

Voice grievance regarding treatment or care that is or fails to be furnished

Be fully informed about a treatment or procedure and the expected outcome before it is performed

Confidentiality of personal medical information

Privacy and Safety

The patient has the right to:

Personal privacy

Receive care in a safe setting

Be free from all forms of abuse or harassment

Advance Directives

You have the right to information on the Center's policy regarding Advance Directives.

Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

If you request, an official state Advance Directive Form will be provided to you.

Submission and Investigation of Grievances: You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

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

Lisa Woodward, RN, Center Director
3344 N. Futrall Ave Fayetteville, AR 72703
479-582-7280

You may contact your state representative to report a complaint;

Arkansas Department of Health
5800 W. Tenth St, Suite 400 Little Rock, AR 72204
501-661-2201
State website: www.healthyarkansas.com

Sites for address and phone numbers of regulatory agencies: **Medicare Ombudsman website**
www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

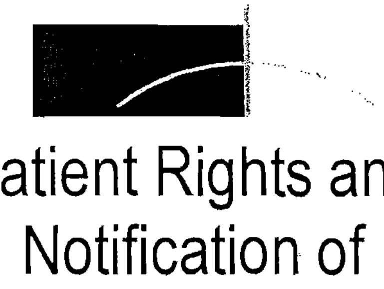
Office of the Inspector General: http://oig.hhs.gov

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

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

____
Signature of Patient or Patient Legal Representative

Date ______________



Patient Rights and Notification of Physician Ownership

North Hills Endoscopy Center
3344 N. Futrall Drive
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479-582-7280

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

AS A PATIENT OF THE NORTH HILLS ENDOSCOPY CENTER, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF THE PROCEDURE.

PATIENT'S BILL OF RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

PATIENT RIGHTS:

•To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

•To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery, and/or services.

•To be provided privacy and security of self and belongings during the delivery of patient care service.

•To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

•To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

•When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

•To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.

•To be free from mental and physical abuse, free from exploitation, & free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

•Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

•Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

•Leave the facility even against the advice of his/her physician.

•Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.

•Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge for the facility.

•To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

•Know which facility rules and policies apply to his/her conduct while a patient.

•Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.

•To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his or her patient record.

•Examine and receive an explanation of his/her bill regardless of source of payment.

•To appropriate assessment and management of pain.

If you need a translator:

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

Date________________

Physician________________

Patient # ________________

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PATIENT REGISTRATION

Please Print

Referring Doctor________________________________
(Name) (City)

Name____
(Last) (First) (Middle)

Permanent Address____________________________________
(Street) (City) (State) (Zip Code)

Mailing Address____________________________________
(Street) (City) (State) (Zip Code)

Home Phone # ________________ Cell #________________ Business Phone # ________________

Age________ Sex________ Date of Birth ________________ Social Security # ________________

Please check one ☐ Married ☐ Single ☐ Widowed ☐ Separated

Patient's Employer ________________________________ Occupation________________

Employer's Address ____________________________________
(City) (State) (Zip)

Nearest Relative (not living with you)________________________(Relationship)________________

Address________________________________ Phone # ________________
(City) (State)

SPOUSE'S INFORMATION **(IF PATIENT IS A MINOR PLEASE LIST RESPONSIBLE PARTY INFO)**

Name of Spouse ________________ Social Security # ________________ Date of Birth ________________
(or Parent)

Spouse's Employer ________________________ Address ________________________
(City) (State) (Zip)

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

MEDICAL INSURANCE INFORMATION

Medicare #________________________ Medipak #________________________ Medipak Plus Yes ☐ No ☐

AR Blue Cross/Blue Shield # ________________________ Group # ________________ Subscriber ________________

OTHER INSURANCE

Primary Ins. Co. ________________________ Address________________________

Policy #________________ Group #________________ Subscriber ________________

Secondary Ins. Co. ________________________ Address________________________

Policy #________________ Group #________________ Subscriber________________

DISCLOSURE AGREEMENT

I have been informed by the Center that the physician who is rendering services may have ownership in the above referenced facility. I have been given the option to be treated at another facility, which I have declined. I wish to be treated at the above referenced facility.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE NORTH HILLS ENDOSCOPY CENTER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN (IF ASSIGNMENT ACCEPTED) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts terms specified above.

________________________ ________________________
Date Signature