

**North Hills
Gastroenterology Endoscopy Center**

Date _____
Physician _____
Patient # _____

PATIENT REGISTRATION

Please Print

Referring Doctor _____
(Name) (City)

Name _____
(Last) (First) (Middle)

Permanent Address _____
(Street) (City) (State) (Zip Code)

Temporary Address _____
(Street) (City) (State) (Zip Code)

Home Phone # _____ 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 has an ownership interest 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

**NORTH HILLS
MEDICAL PARK
Gastroenterology Endoscopy Center**

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

William C. Martin, M.D.

Michael L. Rogers, M.D.

Gary A. Thomas, M.D.

You have been scheduled to have an esophagogastroduodenoscopy (EGD) at North Hills Endoscopy Center. This is an exam that allows the doctor to examine the lining of the esophagus and stomach and to identify any abnormalities.

Please stop any blood thinners (i.e. Aspirin, Ibuprofen, Coumadin, Ticlid, Lovenox, Plavix) one week before this exam.

PLEASE DO NOT EAT OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE YOUR EXAM.

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 to make you sleepy and relaxed just before the procedure begins.

As you lie on your left side, your throat will be sprayed with a numbing medication. A bite block will be placed between your teeth. If you have loose fitting dentures or partial plates, they will be removed before starting the procedure. You will feel the scope passing over your tongue, and will be asked to swallow to help advance the scope. The most important thing to keep in mind is that the scope is not going into your lungs, and you will be able to breathe throughout the procedure.

Often a biopsy (tiny bit of tissue) is taken for microscopic examination. You will not feel any sensation or discomfort when a biopsy is removed. If there is a stricture (narrowing) noted in your esophagus, the doctor may pass a dilator to stretch out that area. This is a flexible rubber tube that is passed into your throat just like the scope.

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 experience a mild sore throat after your procedure. Warm salt water gargles or lozenges may help with this. If you have any severe abdominal or chest pain, fever or bleeding, please call the center.

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

**NORTH HILLS
MEDICAL PARK
Gastroenterology Endoscopy Center**

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

William C. Martin, M.D.

Michael L. Rogers, M.D.

Gary A. Thomas, M.D.

Dear Patient:

Your doctor has scheduled a procedure for you in our facility. Please complete the enclosed patient registration form and bring it with you on the day of your procedure. Please bring your insurance cards 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 this procedure will be performed as an 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. If this is not possible, an acceptable payment agreement can be arranged.

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

Sincerely,

Patient Accounts Department