NORTH HILLS

MEDICAL PARK

Gastroenterology Endoscopy Center

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

William C. Martin, M.D. | Gary A. Thomas, M.D. | Sidney L. Vinson, M.D.
Michael L. Rogers, M.D. | Chad E. Paschall, 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. We encourage you to drink one quart of Gatorade. **DO NOT** eat any solid foods or milk products the day before your exam.

A prescription will be given to you or called in to the pharmacy of your choice.

At 2:00 PM **ON <u>THE DAY BEFORE</u> THE EXAM** you will take 2 Dulcolax (Bisacodyl) tablets.
At 3:00 PM begin drinking the container of Halflytely. You should drink 8 oz glass every 15 minutes.
At 5:00 PM you will take 2 more Dulcolax (Bisacodyl) tablets.
It is important that you drink the <u>entire</u> container of Halflytely.

You may have clear liquids **<u>up to 4 hours prior</u>** to your arrival time.

NOTICE TO THE PATIENT:

<u>ONE WEEK BEFORE</u> YOUR SCHEDULED PROCEDURE, PLEASE <u>DO NOT</u> TAKE ANY IRON SUPPLEMENTS.

- IF YOU ARE ON *COUMADIN, TICLID, LOVENOX OR ANY OTHER* ***PRESCRIBED BLOOD THINNERS OR DIABETES MEDICATION***
- IF YOU ARE **ALLERGIC TO LATEX**
- IF YOU HAVE AN **INTERNAL DEFIBRILLATOR** OR PROSTHETIC MITRAL VALVE
  IF YOU HAVE ANY OF THE ABOVE CONDITIONS, PLEASE CALL OUR OFFICE AND SPEAK WITH A NURSE PRIOR TO YOUR APPOINTMENT

PLEASE <u>TAKE ALL OTHER PRESCRIBED MEDICATIONS</u> WITH A SMALL SIP OF WATER THE MORNING OF YOUR PROCEDURE.

PLEASE <u>BRING A LIST OF ALL CURRENT MEDICATIONS</u> WITH YOU THE DAY 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 CANCELLED OR DONE WITHOUT SEDATION.

Upon arrival, you will be checked in and weighed. We will then take you to an exam room and an IV will be started and you will be given medication to help sedate you. Afterwards, you will be monitored in the recovery room. After getting dressed, the doctor will talk to you and your family. REMEMBER: Someone will need to drive you home afterwards. Plan to be at the Center for 2-3 hours.

Please report to North Hills Endoscopy Center at 3344 N. Futrall Drive. North Hills Endoscopy Center is located inside the Fayetteville Diagnostic Clinic. If you have any questions, please feel free to call a nurse at (479) 582-7280.

Your appointment is: DATE:__________________________ TIME:_____________________

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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, weighted 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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Michael L. Rogers, M.D. **Chad E. Paschall, 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

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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.

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)

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.