Gastroenterology East, P.A. & Endoscopy Center

Jack Cole D.O., Shane Hendon, D.O., Geoffrey You, M.D., Kurt G. Vernon M.D.
Jessica Brown, NP-C, Heather Larsen, NP-C

- DO NOT EAT OR DRINK ANYTHING AFTER 12:00 (MIDNIGHT) THE NIGHT BEFORE YOUR PROCEDURE. THIS INCLUDES: ORAL TOBACCO, CANDY, GUM, WATER, DRINKS OR FOOD.

- BRING ALL MEDICATIONS WITH YOU THE MORNING OF THE PROCEDURE.

- ARRANGE FOR A DRIVER TO COME WITH YOU THE MORNING OF THE PROCEDURE. THE DRIVER MUST PLAN TO STAY AT THE OFFICE AND IS NOT ALLOWED TO LEAVE.

PLEASE UNDERSTAND THAT IF YOU EAT OR DRINK THE MORNING OF THE PROCEDURE OR DO NOT HAVE A DRIVER THAT YOUR PROCEDURE WILL BE CANCELLED.

2210 Hemby Lane • Greenville, NC • 27834
Tel (252) 551-3000 • Fax (252) 551-3100

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Welcome,

We thank you for allowing Gastroenterology East P.A & Endoscopy Center to participate in your care. It is our pleasure to serve you and residents of Eastern North Carolina. Our facility is a physician-owned practice that is operated out of Greenville, North Carolina. We take pride in patient care and safety. We hope that you will be satisfied with the services provided.

Gastroenterology East P.A & Endoscopy Center has been in operation since 2007. The facility performs Colonoscopies and EGDs in an outpatient setting. When you present to the facility, expect to be present for approximately two hours. Your driver will be required to stay at the facility as well. If you become ill prior to your scheduled procedure, please inform our Endoscopy staff. This includes fever and other contagious symptoms.

This packet contains information regarding our facility, our policies, as well as information on your upcoming procedure. Please ensure that you read both the front and back of each page. If you have any questions regarding any of the information presented in this packet, please contact our office at (252)-551-3000.

Packet Contents:

- Map
- Procedure Instructions
- Medication Information (front and back)
- Pre-sedation Interview Form (Please complete and bring day of appointment)
- Medical Appointment Cancellation Policy
- Coding and Billing Policy
- Patient Rights and Responsibilities (front and back)
- Advance Directives Policy
- Grievance Policy
- Patient Registration Form (Please complete and bring day of appointment)
- HIPPA Privacy Practices (Please complete and bring day of appointment)

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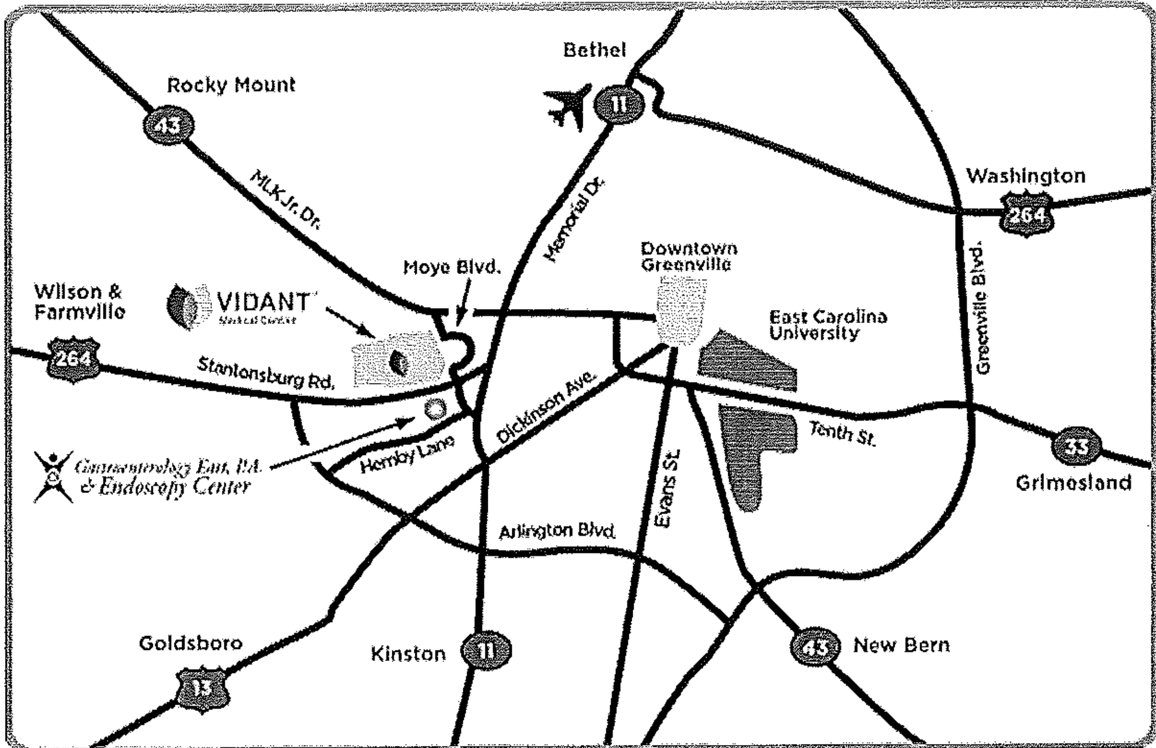

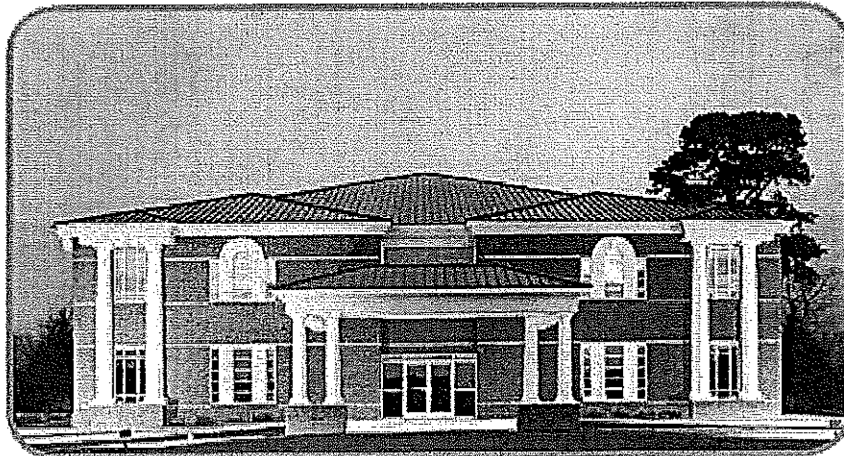

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UPPER ENDOSCOPY

To help you determine your medical treatment, you have been asked to undergo a procedure called an upper endoscopy, which is an examination of your upper digestive tract, which consists of your esophagus and stomach.

This procedure is performed using endoscopes. The endoscope is a narrow, flexible tube. It is passed through the mouth and the back of the throat into the upper digestive tract. The tube will not interfere with your breathing. Abnormalities seen by an x-ray can be confirmed and others may be detected which are too small to be seen on an x-ray. If the doctor sees a suspicious area, he can pass an instrument through the endoscope and take a small piece of tissue (biopsy).

You will be given medication through an I.V. to make you relaxed and sleepy. The procedure is well tolerated with little or no discomfort.

Due to the sedation you will receive, **YOU WILL NEED SOMEONE TO DRIVE YOU HOME**. Your driver is required to bring you to the appointment and must stay for the entire duration of the procedure. **Please do not have someone drop you off or use a cab service**; this could cause your procedure to be cancelled.

You may have a minor sore throat after the procedure or during the next day. Please feel free to ask your doctor or nurse any questions you may have.

PREP INSTRUCTIONS

The night before your test you will be asked **NOT TO EAT OR DRINK ANYTHING AFTER MIDNIGHT!**
NO BREAKFAST THE MORNING OF YOUR PROCEDURE!

Additional Instructions______________________________________

Appointment Date____

Report to Gastroenterology East, P.A. & Endoscopy Center ____________________

Your procedure is scheduled to start at ________________________________

Provider: Jack Cole, D.O. • Shane Hendon, D.O. • Geoffrey You, M.D. • Kurt Vernon, M.D.

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MEDICATION INFORMATION

- Please **STOP** all *Aspirin and Aspirin-containing products* five (5) days prior to your procedure
- If you take *Coumadin, Plavix, Aggrenox, Ticlid, Pradaxa, or other blood thinning agents other than Aspirin*, you need to speak with a RN at our office for further instructions regarding these medications
- Take All AM medicines that are taken for Blood Pressure, Cardiac Issues, Seizures, Chronic pain medicines, SSRI's/ Antipsychotics, or pulmonary drugs.

FREQUENTLY ASKED QUESTIONS

- You may wear your contacts or glasses.
- You may brush your teeth morning of procedure.
- You may wear makeup, nail polish, and jewelry.
- You may wear your dentures. If you are having an upper endoscopy, you will be asked to remove them right before the procedure.

GASTROENTEROLOGY EAST & ENDOSCOPY CENTER
PRE-SEDATION INTERVIEW FORM
(Please complete and bring to appointment)

Name________________________________ Date ___________________________

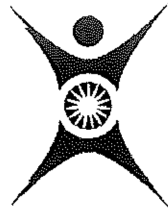
Birthdate ____________________________ Time___________________________

You will soon have an endoscopic procedure performed at *Gastroenterology East, P.A. & Endoscopy Center*. You will receive IV sedation for your procedure. IV sedation will be administered by a Certified Registered Nurse Anesthetist. In order for the nurse anesthetist to safely administer sedation for your procedure, you will need to provide us with information regarding your current health status. This form **MUST** be completed and returned on the day of your procedure. It is not necessary to mail or bring in form prior to your procedure. Thank you.

1. Are you currently taking any medication? If yes, please list_________________________________
   ____
   ____
2. Do you take any blood thinning medications such as Aspirin, NSAIDs, Plavix, Coumadin, Aggrenox, Pradaxa, or Ticlid, etc. (including generics)? **If yes, please indicate medication and last dose:**______________
3. Do you have a history of **(Please circle all that apply):** problems with your heart, blood pressure, stent placement, stroke, lungs, kidneys, diabetes, seizure disorders, liver disorders, blood disorders, depression, arthritis, nervous disorder, organ transplant, migraine headaches?
4. Are you allergic to any medications? If yes, please ____
   ____
5. Do you have a LATEX ALLERGY? ☐ NO ☐YES Describe reaction____________________
6. Are you allergic to EGGS? (One of our medications is egg-based and we will choose a different one if you cannot eat or are allergic to eggs) ☐ NO ☐YES
7. How much do you weigh? _______________ How tall are you?_______________
8. Do you use any tobacco products? ☐ NO ☐YES Smoke/Vap/Chew __________________
9. Do you drink alcohol? ☐ NO ☐YES
10. Do you have a family history of colon cancer, colon polyps, esophageal cancer or gastric cancer (mother, father, brother, sister)?
    ☐ NO ☐YES Relationship____________________________________
11. Circle valuables **you have with you:** Dentures Contacts/Glasses Other: ______________
12. Who may we list as your next of kin? Name:____
    Relationship:________________ Contact Phone: (1)_______________(2)_______________
13. What phone number can we contact you at tomorrow for a follow up phone call: ______________
14. Do you have Sleep Apnea? ☐ NO ☐YES Do you sleep with a CPAP machine at night? ☐ NO ☐YES
15. How many pillows do you sleep with at night? _____________________________________
16. Have you had anesthesia previously for a surgery? ☐ NO ☐YES
17. What surgeries have you had? ____
    ____
18. Did you have any complications with anesthesia such as nausea or hives?
    ☐ NO ☐YES Describe reaction______________________________________
19. Has anyone in your family ever had a problem with anesthesia? ☐ NO ☐YES
20. Is there anything you would like us to know about your health that will help us to take better care of you that we have not asked about?____
    ____
21. What time did you last eat or drink? (Be specific) _____________________________________

PLEASE DO NOT EAT OR DRINK AFTER MIDNIGHT OR YOUR PROCEDURE WILL BE CANCELLED

(You may be directed to take medications with only a sip of water the morning of your procedure).



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Medical Appointment Cancellation Policy

Dear Patient,

At Gastroenterology East, we strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you. When it is missed, that time is not being used to treat another sick patient.

Our Policy is as follows:

We request that you give our office 24 hour notice in the event you need to reschedule your appointment with the provider. This includes procedures and office appointments. This allows other sick patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointed ("No Show"). A fee of $100.00 will be charged to you for a missed appointment.

Additionally, if patient is late for appointment, they may still be seen. However, it will be at the earliest convenience of the provider.

If you have any questions regarding this policy, please let our staff know and we will be happy to clarify any questions you have.

We thank you for your patronage.

Sincerely,

Gastroenterology East Staff

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Important Information for our Patients about our Coding and Billing Policy

We thank you for choosing Gastroenterology East P.A. & Endoscopy Center to assist you with your healthcare needs. Providing you with high quality healthcare is our first priority.

Our coding and billing practices are dictated by the terms of your particular insurance policy, Federal Law, and the American Medical Association. These regulations can be quite complicated and generate many questions from our patients. We are required to submit our claims based on the documentation in the medical record of any service provided to you. Our doctors or staff cannot comply with any request to improperly alter the medical records for the purpose of obtaining payment.

It is our experience that covered benefits, copayments, and deductibles vary greatly from policy to policy. You as the patient are responsible for payment of all copayments and deductibles at the time of your service as per your contract. Our able, skilled insurance office staff will be happy to obtain the proper authorizations and pre-certifications to achieve maximum reimbursement for your services.

Private insurers, as well as the Federal Government, ban the waiving of copayments and deductibles. We are contracted with private insurers and the Federal Government. Those contracts prohibit us from waiving the collection of copayments and deductibles. We are also contractually obligated to collect your copayment and deductibles. Therefore, your copayment and any applicable deductible is due at the time of service.

We look forward to providing you with first class care. Please call with any questions regarding this policy at 252-551-3000.

Respectfully,

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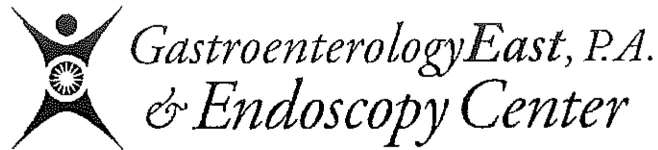

Your Rights and Responsibilities as Our Patient

This center is a physician owned facility. You may exercise the following rights without being subjected to discrimination or reprisal.

Patient Rights – You have a right to:

- Considerate, respectful, and safe care that is free from abuse or harassment.
- A discussion of your illness, what we can do about it, and the likely outcome of care.
- Know the names and roles of the people caring for you here.
- Respectful and effective pain management.
- Receive as much information to consent to or refuse a course of treatment or invasive procedure and to actively participate in decisions regarding your medical care.
- Involve your health care proxy or significant others in the decision making process for medical decisions.
- Reasonable continuity of care and to know in advance the time and location of an appointment as well as the doctor you are seeing.
- Full consideration of personal privacy and confidentiality of your medical information. Your written permission will be obtained prior to releasing any medical information. When we do release your information to others, we ask them to keep them confidential.
- Review your medical record and ask questions unless restricted by law.
- Know of any relationships with other parties that may influence your care.
- Know about rules that affect your care and about charges and payment methods. You have a right to receive and examine an explanation of your bill regardless of the source of payment.
- Receive assistance with the transfer of care from one doctor to another doctor within our practice or to an external doctor not in our practice.
- You have a right to develop a living will or healthcare power of attorney although these will not be honored in this facility. If an emergency occurs, EMS will be called and you will be transferred to the hospital.
- Voice your concerns, complaints, or problems with the care you received by contacting our manager at 252-551-3000. If we are unable to satisfactorily address your complaint, you may contact the NC Medical Board at 1-800-253-9653 or AAAHC 1-847-853-6060 or www.aaahc.org.

Patient Responsibilities - You agree to:

- Provide accurate and complete information concerning your symptoms, past history, current health status, and medications including over-the-counter products and dietary supplements.
- Make known whether you clearly comprehend your medical care and what is expected of you in the plan of care.
- Participate in the development of the treatment plan and follow up care instructions given to you.
- Follow the treatment plan and care instructions given to you.
- Keep appointments and notify us if you are unable to do so.
- Accept responsibility for your actions if you refuse planned treatment or do not follow your doctor's orders.
- Accept financial responsibility for care received and pay promptly.
- Follow facility policies and procedures.
- Inform my doctor about any living will, medical healthcare power of attorney, or other directive that may affect my medical care.
- Be respectful of all healthcare providers and staff as well as other patients.
- Inform the staff of any discomfort or pain and patient safety issues.
- Share your values, beliefs, and traditions to help the staff provide appropriate care.
- Provide a responsible adult to transport you home and remain with you if you receive sedation medications.

Additional Information for Medicare Patients

All issues, concerns, or complaints can be reported by contacting our Office Manager or Nurse Manager. If we are unable to address your concerns, you may contact the following for assistance.

1. Medicare Ombudsman www.medicare.gov/ombudsman/resources.asp

2. NC DHSR Complaint Intake Unit www.dhhs.state.nc.us/dhsr/ciu/complaintintake
   Rita Horton, 2711 Mail Service Center, Raleigh, NC 27699 or 1-800-624-3004 or 1-919-855-4500

Advance Directives – Living Will or Health Care Power of Attorney Resources

For applicable state laws and sample forms for creating a living will or healthcare power of attorney, you may contact one of the following.

1. Caring Information Organization at 1-800-658-8886 for English or 1-877-658-8896 for other languages or www.caringinfo.org

2. NC DHHS Division of Aging and Adult Services at 1-800-662-8859 or www.ncdhhs.gov/aging/direct

3. Carolinas End of Life Care at 1-919-807-2162 or www.carolinasendoflifecare.org

Advance Directive Policy:
Please be aware that we do not honor living wills or do not resuscitate orders at this facility due to the fact that a terminal, incurable, vegetative state is not anticipated in this outpatient setting. If you present to this center for a procedure with a living will or valid Do Not Resuscitate Order (DNR) or Out of Facility form and you have an emergency, we will start CPR and call 911 for transport you to the hospital. EMS will be informed of the Do Not Resuscitate Order or living will upon arrival.

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ADVANCED DIRECTIVES

Purpose:

The purpose of this policy is to establish guidelines for Advanced Directives at ***Gastroenterology East P.A. & Endoscopy Center.***

Definitions:

Living Wills: Generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.

Durable Power Of Attorney for Health Care: A signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

Policy:

1. Patients have the right to develop an Advanced Directive and have it honored at hospitals where serious illnesses are cared for. However, due to the fact that ***Gastroenterology East P.A. & Endoscopy Center*** is an OUTPATIENT facility, for the purpose of performing endoscopic procedures in a safe and uncomplicated manner, **WE DO NOT HONOR ADVANCED DIRECTIVES.**
2. The patient is informed of this pre-procedure and acknowledges in writing that he/she has been informed of this policy
3. If patient should have a complication, the patient will be transferred to the hospital where the hospital's policy on Advanced Directives will be followed.

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Grievance Handling Policy

Purpose

This policy and procedure is designed to allow and encourage patients and families to express their concern regarding care, treatment, services, and patient safety without fear of retaliation from the staff.

Policy:

All patient care will be provided within ethical framework that is determined with consideration of federal and state law, professional Code of Ethics, and Standards of Care. This facility will respect the wishes of the patient and family when complaints arise and will include such person in the discussions of the issue or concern if they so wish.

All patients are informed of the process for reporting concerns or complaints and are given a phone number of the contact person along with the phone number of an external agency if we are unable to handle the issue satisfactorily. Staff members may encounter questions or complaints about care provided in the Center while providing the care or during telephone follow up after procedure. Any staff member may respond to patients' and/or families' complaints. The reporting of any complaint will not compromise the patient's access to further care.

All patient inquiries or complaints deserve professional and prompt attention. The physician and/or nurse manager is responsible for responding to the complaint and will assure that the question, request, or complaint is investigated thoroughly; that corrective action is taken where indicated; and that a complete and accurate response is documented and provided to the patient or family member. During an investigation and response period, employees having direct contact with the patients either for the purpose of providing service or hearing or responding to an inquiry have a duty to treat the patient with respect and professional courtesy even in the face of criticism and unpleasant circumstances. The following procedure describes the centralized repository and the consistent fact finding format for handling complaints.

Procedure:

1. The person receiving the complaint/concern, whether verbal or written, will complete an Incident Report Form. If the employee is unable to provide a satisfactory response to the patient, the complaint will be referred to the Nurse Manager within 24 hours.
2. The signed record will be routed to the person who will investigate the complaint.
3. The person investigating the issue will complete the follow-up portion of the form and will provide the patient or family with the results of the investigation and any action taken. All complaints will be acknowledged by letter within 5 business days. The written acknowledgement will include the following: facility contact information, steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.
4. The completed Incident Report Form is forwarded to the QI Committee/Board.
5. Any complaint not satisfied with the response received may appeal to the next highest level of management. If we are unable to satisfactorily address the patient's complaint, they are instructed to contact the state Medical Board or our accrediting agency.

Patient confidentiality will be maintained throughout the process. Only staff with a "need to know" will be informed of the complaint. If a change in procedure is warranted. Staff will be informed without mention of the specific patient.. Documentation of the investigation will not be included in the Medical Record. Responses will be given to patients, unless mentally incompetent or a minor, then this information will be shared with the nearest relative or legal representative.

GastroenterologyEast, P.A. & Endoscopy Center

PATIENT REGISTRATION FORM

Patient #:________________

<table>
<tr><td colspan="2">Last Name First Name MI</td><td colspan="2">SSN DOB</td></tr>
<tr><td colspan="2">SEX: Race: African American
F ( ) M ( ) Caucasian Hispanic
Asian Other</td><td colspan="2">Referring Physician
Primary Care Physician</td></tr>
<tr><td colspan="4">Mailing Address: City State Zip

E-mail Address:</td></tr>
<tr><td colspan="4">Home Phone Work Phone Cell Phone</td></tr>
<tr><td colspan="4">Employer Name</td></tr>
<tr><td colspan="4">Emergency Contact Name Emergency Contact Phone</td></tr>
<tr><td colspan="4">INSURANCE INFORMATION</td></tr>
<tr><td colspan="2">PRIMARY</td><td colspan="2">SECONDARY</td></tr>
<tr><td colspan="2">Primary Insurance Name</td><td colspan="2">Secondary Insurance Name</td></tr>
<tr><td colspan="2">Policy Holder's Name</td><td colspan="2">Policy Holder's Name</td></tr>
<tr><td colspan="2">Policy Holder's DOB</td><td colspan="2">Policy Holder's DOB</td></tr>
<tr><td colspan="2">Policy Holder's SSN</td><td colspan="2">Policy Holder's SSN</td></tr>
<tr><td colspan="2">Policy Number</td><td colspan="2">Policy Number</td></tr>
<tr><td colspan="2">Group Number</td><td colspan="2">Group Number</td></tr>
</table>

I hereby authorize my insurance benefits to be paid to Gastroenterology East, P.A. realizing that I am responsible to pay non-covered services. I also authorize the use of my health information for purposes of treatment, payment, and healthcare operations. I hereby give consent to healthcare providers of Gastroenterology East, P.A. to evaluate and render medical treatment.

_______________________________________ ____________________

Patient/Representative Signature Date

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_______________________________________ ____________________

Patient/Representative Signature Date

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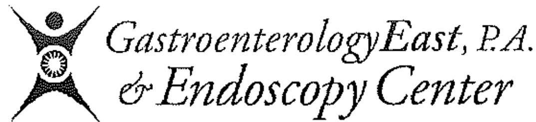

HIPAA Privacy Practice Notification

MRN________________

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version.

What this is all about: Specifically, 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 interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the

patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, 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.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office administrator or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Patient Signature ____ Date ______________

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