FLEXIBLE SIGMOIDOSCOPY

Your procedure is scheduled on ____________________________ Arrive at _______A.M./P.M.

1. **Start a clear liquid diet** after breakfast on the day before your procedure and continue clear liquids throughout the day. 
   **Examples:** Water, Beef or Chicken Broth, popsicle, Jell-O, Coke, Dr. Pepper, Sprite, Coffee with non-dairy creamer, Tea, White Cranberry Juice, White Grape Juice, Gatorade. 

   **NO solid food. NO red, purple, or orange. NO milk or milk products. NO alcoholic beverages.**

2. **Nothing to eat or drink after midnight** the night before your procedure. You may take your usual medications with a small amount of water.

3. Discontinue your **Iron, Aspirin, Blood Thinners, and Arthritis** medications 3 days before procedure.

4. **At 5:00 pm** on the day before your procedure, take 4 Ducolax tablets with a full 8 oz glass of water.

5. **At 6:00 pm** mix 1 bottle of Miralax (238g) and 2 liters of Gatorade (no red, purple or orange) together. Drink one 8 oz glass every 15 minutes until gone. These are available over the counter at any retail pharmacy.

If you are a **diabetic**, you can mix Miralax with a low calorie/low sugar nutritional drink such as **Powerade Zero**.

Please call with any questions you have (806) 467-9820.
1. Please bring someone with you to drive you home. The medication that will be given to you during your procedure makes it impossible for you to drive for 24 hours. This person will also be able to be present when the doctor talks to you to help you remember what he tells you.

2. After you enter the main door you will see two doors. Go through a door on the left that says “Amarillo Endoscopy Center”. There will be a clip board on the desk. Please sign in before you set down.

3. When the nurse calls you back to get ready, your family will be asked to stay in the waiting room. Your family will be called to come in and sit with you after the procedure. No family will be allowed to watch the procedure.

4. The procedure itself will take approximately 20 minutes. After the procedure you will stay in the recovery room for approximately 30 minutes before being discharged. You will be given a drink before you are dismissed unless you are being sent for further tests.

5. Following your colonoscopy you may experience some abdominal discomfort and bloating. This will be relieved by walking around and lying on your left side.

6. Following an EGD you may experience a sore or scratchy throat which may be relieved by using chloraseptic spray or throat lozenges.

7. Discharge instructions will be given to you and your family before leaving and you will have a copy of the instructions to go home with you.
To assure a speedy admission process, please make sure every question is answered accurately and completely.

**Primary Care Doctor**

**What is the reason for your procedure?**

**Have you had or are you being treated for:**
- Yes/No - Heart trouble type
- Yes/No - Pacemaker
- Yes/No - CD [bring your card] (Internal Cardiac Defibrillator)
- Yes/No - High blood pressure
- Yes/No - Lung disease type
- Yes/No - Stroke (Paralysis)
- Yes/No - Cancer type
- Yes/No - Epilepsy or seizures
- Yes/No - Cerebral Palsy/Previous Head Injury/Birth Defect
- Yes/No - Diabetes type
- Yes/No - Thyroid disease
- Yes/No - Jaundice or hepatitis type
- Yes/No - Bleeding tendency
- Yes/No - Kidney disease
- Yes/No - Liver disease type
- Yes/No - Muscular Dystrophy/Multiple Sclerosis
- Yes/No - Muscle weakness
- Yes/No - Arthritis
- Yes/No - Back trouble
- Yes/No - Neck trouble
- Yes/No - Nervous system disease type
- Yes/No - Fatiguing or Dizziness
- Yes/No - Glaucoma
- Yes/No - Stomach problems [Hoisting Hemorrhage/Indigestion]
- Yes/No - Sleep apnea [Bring CPAP machine/mask]
- Yes/No - TMJ problems [Temporal Mandibular Joint: Jaw]
- Yes/No - Bridges
- Yes/No - Dentures
- Yes/No - Dental Caps
- Yes/No - Loose Teeth
- Yes/No - Contact lens
- Yes/No - Hearing Aid
- Yes/No - Do you currently have a head/chest cold?
- Yes/No - Do you have an infusion port? If yes, what physician maintains it? What are your doctors orders for use and repacking?

**ALLERGIES: (food, medicines, etc) Types of reaction:**

**FOR WOMEN ONLY**

Yes/No - Are you pregnant?

Last Period ____________________

**Have you taken or used any of the following in the last 2 weeks?**
- Circle Yes or No
- Yes/No - Alcoholic beverages
- Yes/No - Steroids
- Yes/No - Diet drugs
- Yes/No - Recreational drugs (i.e., marijuana, etc.)
- Yes/No - Blood thinners [Date stopped]
- Yes/No - Tobacco [packs/day]

**Medications: (Include vitamins and herbal)**

Must fill out medications with dose and how often even if this information was filled out in the clinic.

**Name: __________________ mg ______ How Often? __________________**

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

Weight __________________ Lbs. Height ________________

**Anesthesia History**

Date of last anesthetic
- Yes/No - Abnormal reactions? Type
- Yes/No - Nauseas, vomiting?
- Yes/No - Relatives with abnormal reactions to anesthetics?

**Post Surgical Procedures and Hospitalizations:**

(including Psychiatric Treatment)

__________________________

__________________________

__________________________

__________________________

__________________________

Name of person taking you home ___________________

Relationship ___________________

Phone number of person taking you home ____________________

Patient/Guardian Signature _____________________
INFORMED CONSENT FOR FLEXIBLE SIGMOIDOSCOPY, POSSIBLE BIOPSY, POSSIBLE POLYPECTOMY

Explanation of Procedure
This procedure provides direct visualization of the digestive tract with a lighted instrument. Your physician has advised you to have this type of examination. The following is presented to help you understand the reasons for and the possible risks of this procedure.

Principle Risks and Complications of Gastrointestinal Endoscopy
Gastrointestinal Endoscopy is generally a low risk procedure, however, all of the below complications are possible. Your physician will discuss their frequency with you if you desire, with particular reference to your own indications for gastrointestinal endoscopy.
YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST.
1. The bowel may be punctured. This can cause leakage of bowel contents into the abdomen. The risk is higher when polyps are removed depending on how large the polyp is. Fluids and antibiotics will be given and further surgery may be needed. This may require longer stay in hospital.
2. Bleeding from the bowel following a biopsy or damage of large blood vessels may occur. The risk may be greater the larger the polyp. Management of this complication may consist only by careful observation, or may require transfusions or possibly a surgical operator.
3. The procedure may not be able to be completed due to bowel disease or other problems.
4. Polyps or cancer can be missed. The risks are higher if your bowel is not cleaned properly. It is important that you follow the instructions to clear your bowel before the procedure.
5. Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate diagnosis. In a small percentage, a failure of diagnosis or a misdiagnosis may result.

Alternative to Gastrointestinal Endoscopy
Other diagnostic studies or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Our physician will be happy to discuss these options with you.

I consent to the taking and publication of any photographs made during my procedure for the use in the advancement of medical education. I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed of the risks and possible complications of my procedure. I hereby authorize and permit.

_________A. Trehan, M.D.
_________S. Pathapati, M.D.
And whomever he may designate as his assistant to perform upon me the following:
At the time of our examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. If small growths (polyps) are seen, they may be removed.

If any unforeseen condition arises during this procedure calling for (in the physician’s judgement) additional procedures, treatments or operations, I authorize him to do whatever he deems advisable. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of the procedure.

I am aware that in the event of a life-threatening emergency the Center will perform any necessary emergency procedures and transfer me to an acute care facility.

X

Patient Signature/Legally Authorized Representative

Date/Time

Witness

Physician Signature
TO THE PATIENT: Your physician wants you to be informed about your condition and the recommended diagnostic procedure(s) to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This consent is meant to simply make you better informed so that you give or withhold your consent.

It is recommended by the physician performing your procedure(s) that the use of a conscious sedation be administered. Your physician or RN (assisting with your procedure) under the supervision of your physician, will be administering to you an intravenous conscious sedation agent. This agent allows the patient to tolerate the procedure(s) while minimizing anxiety and discomfort.

INTRAVENTOUS CONSCIOUS SEDATION is a controlled state of depressed consciousness that allows protective reflexes to be maintained and permits appropriate response by the patient to physical and verbal commands. Intravenous Conscious Sedation involves risks and hazards in addition to those associated with the proposed procedure(s). Any one of the following may result from the use of an Intravenous Conscious Sedation Agent: Cardiac/Respiratory arrest, respiratory difficulties, drug reaction, convulsions, brain damage or death.

1. I (we) understand that Intravenous Conscious Sedation involves additional risks and hazards but I (we) request the use of an Intravenous Conscious Sedation Agent for the relief and protection from pain during the planned procedure(s). I (we) realize the anesthesia agent may have to be changed possibly with advance explanation to me (us).

2. I (we) fully understand that serious illness, injury or death can result from the use of an Intravenous Conscious Sedation Agent ad described above.

3. I (we) have discussed my condition with my physician and have been given full opportunity to ask questions about my condition, and the option of receiving an Intravenous Conscious Sedation Agent, alternative forms involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

4. I (we) do hereby authorize the administration of an Intravenous Conscious Sedation Agent to the patient by the physician or by a qualified substitute.

5. I (we) certify that this form has been fully explained to me, that I (we) have read it or had it read to me, and I (we) understand its contents.

___________________________________________  __________________________________
Patient Signature/Legally Authorized Representative  Date/Time

________________________________________________________________________
Witness  Physician Signature
DISCLOSURE OF OWNERSHIP

The Amarillo Endoscopy Center is a corporation your physician does have a financial interest in. The physician has become an owner as a result of their commitment to quality health care and service to their patients. Please be advised of the following:

1. For patients other than Medicare and Medicaid, a surgical deposit may be required prior to Endoscopy procedures. Cash, credit card or check will be accepted.
2. You have the right to choose where to receive services.
3. Alternative source of services are available at: Baptist Saint Anthony’s Hospital or Northwest Texas Hospital.

By my signature below, I am acknowledging my understanding of this notice of Disclosure of Ownership interest on the date set forth below.

X____________________________________________          _______________________________________
Patient’s Signature                                                                                 Date

_____________________________________________            _______________________________________
Patient’s Guardian/Representative                                               Relationship

_____________________________________
Witness

I request that payment under the medical insurance program be made to AMARILLO ENDOSCOPY CENTER on any bills of services furnished by AMARILLO ENDOSCOPY CENTER during the next 12 month period.

X___________________________________________            ______________________________
Patient Signature                                                                      Date
Advanced Directive Information

**Directive to Physician, Family or Designated Other (Living Will)**
Directives are written or oral instructions that tell your doctor(s), other health care providers and family what your wishes are should you develop a terminal condition. Upon execution of the Directive, a copy must be presented and made part of each admission to the hospital. Please note that any invasive procedure will suspend an existing directive.

Do you have a directive? (Living Will) Did you bring it?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Medical Power of Attorney**
This form appoints someone in writing to make medical decisions for you if you become unable to do so. Upon execution of the Medical Power of Attorney, a copy must be presented and made part of each admission to the hospital.

Do you have a Medical Power of Attorney? Did you bring it?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If you answered no to any of the above you may do one of the following:

- [ ] Provide an existing document
- [ ] Execute a new document
- [ ] Choose not to execute

If a copy is not available, what are the patient’s wishes?

_______________________________________________________________________________________

**Legal Next of Kin**

Name _____________________________________ Relationship (Circle One)

<table>
<thead>
<tr>
<th>Spouse</th>
<th>Grand Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>Step Parent</td>
</tr>
</tbody>
</table>

Address ___________________________________

Phone #’s ___________________________________

Name – Medical Power of Attorney

_______________________________________________

Name – Medical Power of Attorney

_______________________________________________

Nearest Relative

Appointed Designee – must have signed

Power of Attorney

Patient Signature____________________________

Date _______________
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL Co-Pays are EXPECTED AT THE TIME OF SERVICE. If you do not have your co-pay we will reschedule your appointment.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. We accept cash, personal checks (in-state only), VISA, MasterCard, Discover, American Express and Care Credit. There is a $35 service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality.

INSURANCE:
We bill insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to ensure all charges are paid either by you or by your insurance carrier.

If you need assistance or have questions, please contact The Billing Office between 8:30 a.m. and 5:00 p.m., Monday through Friday at 806-467-2822.

REFUNDS:
Patient/guarantor credits in amounts less than $20 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts of $20 and greater will automatically be refunded to the patient/guarantor.

MANAGED CARE:
If you are enrolled in a managed care insurance (i.e., HMO), you must have a referral from your primary physician in order to see us as we are a Specialist.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

If it becomes necessary to forward your account to a collection agency, in addition to the amount owed, you also will be responsible for the fee charged by the collection agency for costs of collections.
PATIENT BILL OF RIGHTS

Dr. Amit Trehan and Dr. Srinivas Pathapati have established this Patient’s Bill of Rights as a policy with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedence has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The right of efficient and equal service, regardless of race, sex, religion, ethnic background, education, social class, physical or mental handicap, or economic status.
2. The right of considerate, courteous and respectful care from all staff of the facility.
3. The right of complete information in terms that the average patient can reasonably be expected to understand.
4. The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. Alternatives to the proposed procedure must be discussed with the patient.
5. The right to know the names, titles, and professions of the facility staff to whom the patient speaks and from whom services or information are received.
6. The right to refuse examination, discussion and procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal.
7. The right of access to patient’s personal health records.
8. The right of respect for the patient’s privacy.
9. The right of confidentiality of the patient’s personal health record as provided by law.
10. The right to make a complaint and to have your complaints reviewed in a timely, confidential manner.
11. The right to examine and receive a full explanation of any charges made by the facility.
12. The patient has the right to know the facility rules and regulations and how they apply to his/her conduct as a patient.
13. The patient has the right to request information regarding the ownership of the facility.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

PATIENT RESPONSIBILITY

1. You need to give complete, accurate information about your health, including present condition, past illnesses, hospitalizations, medications, natural products and vitamins and any other matters or changes that pertain to your health.
2. Tell your healthcare team if you do not understand what they are telling you, or if you need more information.
3. You and your healthcare team should agree on a treatment plan. If you are unable to follow the plan, tell your doctor or nurse.
4. If you are not able to keep an appointment, please call the office as soon as possible to change the appointment.
5. Treat other patients, visitors, and medical staff with courtesy, compassion, and respect.
6. We encourage you to leave your valuable at home. The doctor’s office is not responsible for lost or stolen belongings.

If you believe any of your rights have been violated or you have other concerns or complaints about your care facility, you may contact the following:

Texas Department of State Health Service
Health Facility Compliance Group
Post Office Box 149347
Austin, Texas  78714-9347
(888) 973-0022

Complaints may be registered with the department by phone or in writing. A complainant may provide his/her name, address, and phone number to the department. Anonymous complaints may be registered. All complaints are confidential.