Columbia Gastrointestinal Endoscopy Center
2739 Laurel Street, Suite 1B
Columbia, SC 29204

PLEASE REVIEW THIS PACKET THOROUGHLY AT LEAST 3 DAYS BEFORE YOUR PROCEDURE

- **You must have someone to drive you home! We cannot discharge a patient to a taxi, unless you have a family member or friend riding with you. We do insist that your driver remain at the Center until you are discharged. Estimated wait time is 45 minutes-1 ½ hours. Times may vary depending on circumstances.**
- **The physician will speak to your driver regarding your post op instructions, please make sure that you come with someone you don't mind hearing these instructions.**
- **Please bring current insurance information (cards) and Photo ID.**
- **Please complete the blank forms attached and bring with you, as we are required to maintain separate records from your doctor's office.**
- **Wear comfortable loose fitting clothing (a two piece outfit)**
- **The Endoscopy Center staff will call you on the next business day to ensure you are doing well, if we are unable to contact you personally, we will mail you a post-card.**

Location
The Columbia Gastrointestinal Endoscopy Center is located at 2739 Laurel Street, Suite 1B; across from Providence Hospital in downtown Columbia. Call 803-254-9588 for specific directions.

BE ADVISED: Your driver is required to stay at our facility at all times while you are having your procedure. Your procedure will be delayed if your driver leaves, if the doctor's schedule allows a delay. If not, your procedure will be rescheduled. This is required for all patients receiving anesthesia.

If you have any questions, please call the appropriate phone number below:

Prep and Instructions:	803-799-4800
Date and Time of Procedure	803-799-4800
Physician Billing or Professional Fee	803-799-4800
Columbia Gastrointestinal Endoscopy Center	803-254-9588

Procedure/Facility billing call-1-855-432-8018 **Anesthesia billing call 1-855-836-1906**

(Someone from these numbers may try to contact you to verify and review your benefits for your procedure.)

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Understanding Billing and Charges

We are committed to helping you understand and prepare for potential out-of-pocket costs related to medical services you or a loved one may receive at our Endoscopy Center, and we have resources available to assist you. Please contact the billing office at 855-836-1904 at any time prior to your procedure to discuss your specific care needs and the potential associated charges. If you are insured, you also should contact your insurer to understand their coverage of services.

Please contact your insurance provider BEFORE your procedure for your deductible and copayment information. Any amounts that have not been met or that are your responsibility will be collected upon your arrival to the facility. Our billing office will contact you via phone or text message to inform you of your financial responsibility; you may contact them at 1-855-836-1904. * The Columbia Endoscopy Center is a separate business from Columbia Gastroenterology Associates. Our facility maintains separate records and has separate billing from the physician's office.**

YOU WILL RECEIVE A BILL FROM:

1. The Endoscopy Center: Columbia ASC, LLC (d.b.a. Columbia GI Endoscopy Center, this is the Facility Fee (where the procedure was performed); billing office in Nashville TN. **1-855-432-8018**

2. Anesthesia Group: Amsurg Columbia Anesthesia, LLC; (anesthesia fee) billing office in Nashville TN. **1-855-836-1906**

3. Your physician at Columbia Gastroenterology Associates (physician's fee for performing the procedure) 803 799-4800.

4. If you have biopsies taken during your procedure, the specimens will be sent to Columbia Gastroenterology Pathology Services. The pathologist analyzing your biopsy will bill you for their professional Services through APS Lab. If your insurance requires a particular laboratory be used for specimen analysis: **you must present this requirement at the time of check in**; the endoscopy center staff cannot verify this on all patients and **will not take responsibility** for sending specimens to an out of network lab.

Please bring the next 2 pages (COMPLETED) with you on your procedure day.

Columbia GI Endoscopy Center- Complete and bring with you

Doctor's Name_____Account_____

PATIENT INFORMATION

PATIENT:_____ SOCIAL SECURITY #: _____

ADDRESS:_____DATE OF BIRTH: _____ AGE: _____

CITY_____ COUNTY_____ Phone: HOME_____Cell_____

STATE_____ZIP_____FEMALE_____MALE_____Marital Status_____

RACE (Please Circle) Caucasian African American Asian American Indian Other_____

ETHNICITY (Please Circle) Hispanic or Latino Non-Hispanic or Latino

MARITAL STATUS_____E-mail Address_____Drivers License#_____

FAMILY PHYSICIAN (REFERRING PHYSICIAN _____

HAVE YOU HAD A PREVIOUS PROCEDURE AT OUR CENTER? YES NO (PLEASE CIRCLE ONE)

DO YOU HAVE A LIVING WILL? YES NO IF NOT, WOULD YOU LIKE INFORMATION? YES NO

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE _____

ADDRESS:_____CITY_____

STATE_____ ZIP_____CONTACT: _____

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS_____CITY, STATE, ZIP_____

MEMBER # _____ GROUP# _____

NAME OF INSURED_____INSURED SOCIAL SECURITY _____

INSURED DATE OF BIRTH _____RELATIONSHIPTO PATIENT

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS:_____CITY, STATE, ZIP

MEMBER # _____ GROUP#

NAME OF INSURED:_____INSURED SOCIAL SECURITY:_____

INSURED DATE OF BIRTH _____RELATIONSHIPTO PATIENT

EMERGENCY NOTIFICATION

CONTACT:_____TELEPHONE:_____

RELATIONSHIP:_____ RESPONSIBLE PARTY: _____

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Signed (Patient or Responsible Party)_____Date_____

Medical History Form-PLEASE COMPLETE THE ENTIRE FORM –

We are a SEPARATE entity from the physician's office. We require this information since we do not have access to your office records. Complete and bring with you

- **CIRCLE** the procedure you are having done - **COLONOSCOPY / EGD-Upper endoscopy / Dilation /Flex Sig**

- **WHY** are you having the procedure done today? **Please CIRCLE all that apply:**

Age related colon screening exam, History of colon polyps, History of colon cancer, Family history colon cancer, Diarrhea, Abdominal pain, Constipation, Rectal bleeding, Blood in stool, Hx. Crohns/Ulcerative Colitis, Reflux, Heartburn, Difficulty swallowing, Nausea, Vomiting, Other _____
Have you had a colonoscopy in the past? _____If yes, how long ago was your last colonoscopy? _____

- Are you **ALLERGIC** to any medications, including over the counter meds, or any foods? __YES __NO

If you have any allergies (including food allergies) please **LIST** them as well as the reaction you have:
Med/food:_____ Reaction: _____ Medication: _____ Reaction_____
Med/food: _____ Reaction: _____ Medication: _____ Reaction: _____

- Colonoscopy pts, **CIRCLE** the prep you used? Pien-Vue, Nulytely, Trilyte, Colyte- (GALLON containers), Suprep (Two 6 oz bottles), Clen-Piq (two bottles) , other _____. Please inform the nurses if you had difficulty with the prep
  Do you feel the prep worked? Describe results i.e., Clear, yellow, brown with residue, Blood seen

- **MEDICAL HISTORY:**

☐Yes ☐No – Fallen in the past year? ☐Yes ☐No WC, Walker, Cane ☐Yes ☐No CVA or Parkinson's gait imbalance
☐Yes ☐No - DIABETES-medication taken today? _____ Insulin Pump? _____AM blood sugar_____
☐Yes ☐No - ARTHRITIS
☐Yes ☐No - LUNG DISEASE Type_____ (Asthma, Emphysema, Chronic Bronchitis etc.)
☐Yes ☐No –SLEEP APNEA, C-PAP MACHINE? Yes____ No_____
☐Yes ☐No - SEIZURE DISORDER Date of last seizure_____
☐Yes ☐No – CANCER Type_____
☐Yes ☐No - HEART DISEASE Type_____
☐Yes ☐No - ARTIFICIAL HEART VALVE
☐Yes ☐No – BLOOD THINNERS (Plavix, Eliquis, Lovenox, Coumadin, Aspirin, etc.) Last dose date? _____
☐Yes ☐No –HIGH BLOOD PRESSURE- Medication taken today? _____
☐Yes ☐No – ENDOCARDITIS (Heart infection)
☐Yes ☐No - LIVER DISEASE, HEPATITIS, HIV_____
☐Yes ☐No – ARTIFICIAL JOINTS, pins Location_____ Year performed_____
☐Yes ☐No – INTERNAL STIMULATORS i.e. nerve, spinal, bladder
☐Yes ☐No – CARDIAC DEFIBRILLATOR
☐Yes ☐No – GLAUCOMA
☐Yes ☐No –KIDNEY DISEASE or DIALYSIS? YES_____NO_____
☐Yes ☐No Smoker/Vape: Never, Former, year quit:_____ **Current Smoker/ Amt**__ Alcohol /Amt. Illicit Drugs Type_____

- **SURGERIES: Have you had ANY surgical procedures done ____YES _____ NO (Please list ALL surgeries)**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

- **MEDICATION LIST: VERY IMPORTANT(List ALL medications you take, dose and amounts)**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please list any valuables you need secured _____ Please list any special religious considerations _____

- **____ Please initial that you understand that your driver must remain at the center while you are here**
- **Drivers name _____Patients Signature _____ Date _____**

Patient's Rights and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care.
- To be provided privacy and security 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, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. 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.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- 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 from 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.
- To be informed of their right to change providers if other qualified providers are available.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' 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 care The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and to support participation of the caregiver in decisions affecting medical treatment.

PATIENT RESPONSIBILITIES:

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- To accept personal financial responsibility for any charges not covered by their insurance.
- To be respectful of all healthcare professionals and staff, as well as other patients

If you need an interpreter:

If you will need an interpreter, **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.

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 a 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

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in South Carolina Statutes §44-77-10-160. In the State of South Carolina and federal law give all competent adults, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If certain treatments are not wanted, they have the right to tell their doctor, either orally or in writing, they do not want them. If they want to refuse treatment, but they do not have someone to name as their agent, you can sign a living will.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Columbia Gastrointestinal Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.
If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:
Cindy Sease, RN-Administrator
2739 Laurel Street, Suite 1B
Columbia, SC 29204
803 254-9588

You may contact the state to report a complaint;
South Carolina Health & Human Services
PO Box 8206
Columbia, South Carolina 29202
888.549.0820
State Web site: https://www.scdhhs.gov/

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman. **Medicare Ombudsman Web address:** www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsmam.html

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

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

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

Physician Financial Interest and Ownership: **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.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Anthony D. Lowman, MD, Walter J. Bristow, MD, Jorge L. Galan, DO, Edward E. Kimbrough, MD, and George T Postic, MD.