Western Washington Medical Group
Gastroenterology

Dear Patient:

Thank you for choosing Western Washington Medical Group Gastroenterology Physicians to provide your medical care.

Enclosed you will find the information that will help you prepare yourself for your upcoming procedure at our Endoscopy Center. This information includes:

1. Brochure describing the Endoscopy Center and what you should expect.(map included)
2. Informed Consent for Gastrointestinal Endoscopy
3. Patient Self Referral Act
4. Patient Rights and Responsibilities
5. Procedure Preparation Instructions
6. Frequently Asked Colonoscopy Preparation Questions

7. Patient Registration Form
8. Financial Policy
9. Friends and Family Form
10. Medication List

Once completed, **please mail or fax forms 7-10 to:**

WWMG – GI Department
4225 Hoyt Avenue, Suite A
Everett, WA 98203-2351 Fax: 425-252-9860

The Endoscopy Center **requires that you have a driver who will remain on the premises during your entire stay.** Plan for you and your driver to spend **2 ½ hours** at the Endoscopy Center.

The reception staff will verify that your escort/driver has accompanied you at the time of your check in. **If your escort/driver does not check in with you or chooses to not remain at the Endoscopy Center, your procedure will be cancelled, rescheduled and a late cancellation fee charged.** The Center does not have the facilities or the staffing available to keep a patient, who has been sedated, for many hours after his/her procedure.

The following steps are very important; if they are not followed it could result in your insurance not covering your exam, or your exam being cancelled.

- If your insurance plan requires a referral, and one has not already been obtained, please contact your Primary Care Physicians' office and ask them to send a referral to our office as soon as possible. This referral must cover both the physician who is performing the exam, as well as Western Washington Medical Group Endoscopy Center, which is the facility where we typically perform these exams. You will be given the name of the physician at the time that your appointment is scheduled.

- Call your insurance company and ask if your plan will cover a **screening examination.** This is a very important step. You should also know that if pathology (i.e. polyps or inflammation) is found on the exam, the procedure may not be paid as a screening exam. Here are the procedure numbers that your plan may need.

  □ Colonoscopy (CPT code 45378-45385)
  □ Upper GI Endoscopy (CPT code 45235-43239)

- We will require a copy of the front and back of your insurance card at least two weeks prior to your scheduled appointment. Many plans require **pre-authorizations** for these procedures which may take several days to get through their medical review process. This is true even if your insurance does not require a referral. Please note that if we do not receive a copy of the insurance card, you will be listed as a **self pay** patient and will be held personally responsible for the entire balance. Partial pre-payment of $500 is required at the time of service; balance will be due upon receipt of statement.

Please mail or fax a copy of **both sides** of your insurance card to:

WWMG - GI Department
Attn: Pre-authorization Dept.
4225 Hoyt Avenue, Suite A
Everett, WA 98203-2351 Fax: 425-252-9860

If you should have any questions or concerns regarding any of this information please give our office at call at (425) 259-3122.

Sincerely,

The Physicians and Staff of Western Washington Medical Group Gastroenterology and Endoscopy Departments

Western Washington Medical Group
Endoscopy Center

COPY ONLY – DO NOT SIGN THIS DOCUMENT

(You will receive a copy of this consent form at the Endoscopy Center on the day of your procedure, you will be asked to sign it in front of a witness at that time. The staff will be happy to answer your questions at that time.)

INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

PATIENT NAME:_____DATE OF BIRTH_____

Washington State Law guarantees that you have both the right and the obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form will acknowledge your acceptance of treatment recommended by your physician.

1. I request that_____or such associates as may be designated to perform the following procedures(s) upon me:

2.
_____Sigmoidoscopy/Colonoscopy with possible biopsy and/or polypectomy
_____Upper GI endoscopy/possible biopsy/polypectomy/dilation.
_____Upper GI endoscopy with Bravo pH capsule placement.
*Endoscopic photography may be done at selected intervals during the procedure.
_____Upper GI endoscopy with Pill Cam placement.

3. I consent to the administration of intravenous sedatives and possible anesthesia or other medications before, during and after the procedure by _____or other qualified medical personnel. I understand that all sedatives/anesthetics involve the rare potential of risks and complications such as damage to vital organs including the brain, heart, lungs, liver, spleen and kidneys; paralysis, cardiac arrest, and/or death from both known and unknown causes. I understand that these medications involve the potential of risk to a fetus in the event of pregnancy, of most concern in the first trimester, resulting in miscarriage or deformity. I understand that on rare occasion IV sedatives may cause phlebitis at the IV site.

4. I understand that there are potential risks and complications with any medical or surgical procedure. I acknowledge that no guarantee has been made to me about the results of this procedure. Although it is impossible to list every potential risk and complication, I have been informed of some of the possible risks and complications of this procedure which may include but are not limited to the following: perforation of the colon (large intestine), or esophagus, perforation of esophagus with dilation, perforation of the colon with sigmoidoscopy, bleeding of the colon if large polyps are removed; splenic injury; adverse reactions to medications; aspiration of stomach contents; and the possibility of missed lesions. I understand there is a slight and unknown risk to the fetus if I am pregnant. Complications associated with the Bravo system include premature detachment of the capsule, failure of the capsule to slough off in a timely period, or discomfort associated with the capsule requiring endoscopic removal. Risks involved with Pill Cam capsule endoscopy include retention of the capsule requiring surgical retrieval and injury to the intestinal tract if undergoing MRI scan prior to passage of the capsule.

   These potential risks and complications could result in the need to repeat the procedure, additional medical or surgical treatment or procedures; hospitalization; blood transfusions; or very rarely permanent disability or death. I recognize that during the course of treatment conditions may require additional treatment or procedures and I request and authorize my physician and other qualified

medical personnel to perform such treatment or procedures as is required. The alternatives to endoscopic procedures are typically barium studies, such as upper GI series or barium enema.

PLEASE PUT YOUR *INITIALS* AT YOUR PREFERENCE FOR #5

5. ***Should there be an accidental needle stick or contamination of body fluid*** to any employee of The Endoscopy Center, the Endoscopy Center will test your blood for any infectious diseases, including HIV and hepatitis.

   I do_____ or do not_____ want the **result** of this blood test ***if this blood test is done.***
   (INITIAL ONE OR OTHER ABOVE)

6. I will comply with these instructions **if** I am given sedative/analgesic medications because I realize **no matter how well I feel my judgment will be affected** for the remainder of the day.

   - *I will not* drive for the remainder of the day.
   - *I will not* handle any potentially dangerous machinery, i.e. chainsaw, lawn mower, etc.
   - *I will not* drink any alcoholic beverages for 12 hours.
   - *I will not* sign any legal documents for 12 hours.

6. Written discharge instructions will be reviewed and a copy sent home with me. I will read them and comply with them.

7. Any questions I had regarding gastrointestinal endoscopy that apply to my clinical circumstances have been answered to my satisfaction.

8. I have received information regarding Advance Directives, Patient Rights and Responsibilities and Physician Ownership.

My escort's/drivers name is_____

He/she is my_____(relationship)

_____ _____
Signature of Patient or Authorized Individual Relationship of Authorized Individual

Witness: The Patient/Authorized Individual has read the forms or had it read to him or her.
The Patient/Authorized Individual expresses understanding of the form.
The Patient/Authorized Individual has no questions.

_____ _____ _____
Signature of Witness Date Time

THE RISKS, BENEFITS, AND ALTERNATIVES HAVE BEEN EXPLAINED TO THIS PATIENT OR PATIENT'S REPRESENTATIVE BY ME OR MY ASSOCIATE.

_____M.D.

_____DATE

Western Washington Medical Group
Endoscopy Center

To our patients:

"PATIENT SELF-REFERRAL ACT OF 1995"

Beginning January 1, 1995 any physician investor and the entity to which the physician refers a patient must make certain disclosures to the patient.

By this statement, let it be known those physicians Jerome R. Waldbaum, M. D., and Friedrich C. Loura, M. D., W. Michael McDonnell. M. D., Edward A. Slosberg, M. D., James Z. Mu, M. D., and Sujoy K. Ghorai, M.D. are currently physician investors in ***The Endoscopy Center - Western Washington Medical Group***, an ambulatory surgery center. These physicians have chosen The Endoscopy Center for a variety of reasons. The most significant reason is that the facility was designed and built specifically for gastrointestinal endoscopy to meet the special needs of our patients. Secondly, the staff of the Endoscopy Center consists of gastroenterology nurses who have been specifically trained to assist in all endoscopic procedures. The physicians thereby have the advantage of working with the highest quality of gastrointestinal nurses in the Puget Sound area. This will contribute to the highest level of quality care.

Another reason for the physicians' participation was to take an active part in controlling the ever increasing medical costs associated with endoscopic procedures. Procedures performed at other ambulatory surgery center and the local hospitals are considerably higher than the cost of procedures performed at the Endoscopy Center of Western Washington Medical Group. A list of alternate facilities where endoscopic procedures can be performed is available upon request at the reception desk. These facilities include: Providence Regional Medical Center Everett - Colby Campus, and Stevens Hospital.

Western Washington Medical Group
Endoscopy Center

PATIENT RIGHTS AND RESPONSIBILITIES

The medical staff of The Endoscopy Center have adopted the following list of patient rights and responsibilities. This list shall include, but is not limited to:

THE RIGHT TO:

- Be treated with respect, consideration and dignity.
- Know the name and professional status of those caring for you.
- Clear and complete information concerning your condition and care, significant risks involved, reasonable medical alternatives, and a prediction of the effect on you. When it is medically inadvisable to give such information, the information is provided to a person designated by you or to a legally authorized person.
- Personal privacy and confidentiality of information, and, except when required by law, the opportunity to approve or refuse the release of disclosures of medical information.
- Seek another medical opinion or change physicians as well as refuse treatment or leave the center, even if this is against medical advice.
- Receive a copy of your bill and an explanation of the charges, regardless of source of payment.
- Be informed that advanced directives cannot be honored in this facility and to be advised that should an unexpected life threatening event occur, you will be transferred to a facility that will honor your directive.
- Express any comments, concerns or grievances regarding the care provided to you.

THE RESPONSIBILITY TO:

- Actively participate in decisions involving your care and treatment.
- Be as accurate and complete as possible when providing information about your medical history, allergies, sensitivities and **all** medications you are taking.
- Cooperate fully on mutually accepted courses of treatment or notify your physician if you do not wish to follow his or her advice or instructions.
- Inform your physician or nurse if you do not understand the plan of treatment and what is expected of you.
- Notify your physician or nurse if you notice any changes in your health.
- Act in a considerate and cooperative manner and respect the rights and property of others. Concealed weapons, abusive, threatening or inappropriate language or behavior will not be allowed or tolerated.
- Accept personal financial responsibility in payment of your bill.

Our goal is to provide the best experience possible while in The Endoscopy Center. **Please fill out our patient questionnaire prior to your discharge.** Patients, clients, families or visitors have the right to express complaints or concerns about any aspect of their care or experience. Concerns may be directed to any staff member or the Endoscopy Center Nurse Manager or comments can be mailed to:

The Endoscopy Center
Nurse Manager
12800 Bothell-Everett Hwy Suite 200
Everett, WA 98208

Should you feel your concerns are warranted you may contact: **Office of The Medicare Ombudsman** www.medicare.gov. or mail your complaints to:

Department of Health
Facility and Service Licensing
P.O. Box 47852
Olympia, WA 98045

WESTERN WASHINGTON MEDICAL GROUP **REGISTRATION FORM**
DEPARTMENT OF GASTROENTEROLOGY & ENDOSCOPY

ACCOUNT#_____ NEW ____ UPDATE ____

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME
DATE OF BIRTH	SEX M F	RACE ETHNICITY		SOCIAL SECURITY # PREFERRED LANGUAGE	
MAILING ADDRESS		APT #	CITY	STATE	ZIP CODE 4 DIGIT
STREET ADDRESS		APT #	CITY	STATE	ZIP CODE 4 DIGIT
HOME PHONE ( )		WORK PHONE ( )	EXT	CELL PHONE ( )	
REFERRING DOCTOR				MARITAL STATUS MARRIED ____ DIVORCED ____ OTHER ____	
PRIMARY CARE DOCTOR				SINGLE ____ WIDOWED ____ SEPARATED ____	
PHARMACY NAME, PHONE NUMBER AND LOCATION				PREFERRED EMAIL ADDRESS	

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED_____ OR DISABLED_____)

EMPLOYER NAME			OCCUPATION	
STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT	

PRIMARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME		SUBSCRIBERS EMPLOYER	
SUBSCRIBERS DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___	SUBSCRIBERS ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME		SUBSCRIBERS EMPLOYER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX MALE ___ FEMALE ___	SUBSCRIBERS ID #	GROUP NUMBER

EMERGENCY CONTACT (NOT LIVING WITH YOU)	NAME	RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL ( )

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

____ SELF (* If self do not fill in right field.)	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI
____ SPOUSE ____ PARENT ____ GUARDIAN	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT
	HOME PHONE ( )	WORK OR CELL PHONE ( ) EXT	DATE OF BIRTH	SEX M F

WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE _____ ***DATE***

For office use only
Dr._____ Ins. code_____ Acct #_____ Initials ____

Western
Washington
Medical Group

FINANCIAL AGREEMENT

We consider all patients as **"private"** unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "**private**" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient's responsibility to check their benefits prior to being seen.
*Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there will be an **additional $15.00 fee** charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge **$35.00** for any NSF checks. (per RCW 62A-3-515 & 520)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.
I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name_____ DOB_____

Signature_____ Date_____

DATE:

Western Washington Medical Group
Gastroenterology

PATIENT NAME:

DATE OF BIRTH:

PHARMACY NAME

PHARMACY PHONE #

LOCATION

PHARMACY FAX #

Please list all medications including **over the counter medications, vitamins, antacids and herbal preparations that you are currently taking.

Aspirin ☐ Ibuprofen/Advil/Aleve ☐ Arthritis medication ☐

DATE STARTED	NAME OF MEDICATION, DOSE	# of times per day	PRESCRIBED BY
	EXAMPLE		
9/10/2009	NEXIUM 40 MG	1 x per day	Dr. XYZ

Western Washington Medical Group
Gastroenterology

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary and appropriate. I understand that information is limited to verbal discussions and that **no paper copies of my Personal Healthcare Information (PHI) will be provided without my signature** to release information from my chart. I, the patient, may be asked to sign a Release of Record to release WWMG to share information if my provider and his/her designee deem it necessary.

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.

Please provide us with **YOUR *best most current*** phone contact information. This information will become part of your permanent medical record unless/until you change it. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number: _____ Cell Work Home OK to leave detailed message Y N

Second phone number: _____ Cell Work Home OK to leave detailed message Y N

Third phone number: _____ Cell Work Home OK to leave detailed message Y N

X_____ _____
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

X_____ _____
PRINTED name of person signing DATE

Western Washington Medical Group
Gastroenterology

Office Appointment Late Cancellation and No Show Policies

Late cancellations or no-shows cause unnecessary longer wait time for patients who need to be seen in the office. In order to provide quality medical care in a timely manner, we have to implement a no show/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

To cancel and/or reschedule an office appointment, patients must call 425-259-3122 during business hours (Monday through Friday 8:30am to 5:00pm, closed 12:00pm to 1:00pm for lunch).

Advance cancellations: If an office appointment is canceled or rescheduled ***48 hours before*** the scheduled time, it is considered an advance cancellation and there will be no cancellation or reschedule fees.

Late cancellations: If an office appointment is canceled or rescheduled ***within 48 hours of*** the scheduled time, it is considered a late cancellation. The patient will be charged a late cancellation fee of $50.

No-Show: if patient fails to present at the time of a scheduled appointment without any prior notice, it is considered a "no-show". The patient will be charged a "no show" fee of $100.

Insurance companies will not be billed for this fee, which is the sole responsibility of the patient. The patient will not be charged if there was a true medical emergency and the patient was in the ER or hospitalized at the time of scheduled appointment.

Payment schedule: From the date of the no-show or late cancellation the patient has 60 days to make the payment for the no-show or late cancellation fee.

- During the 60 days before payment is made by the patient, the patient must make a $100.00 deposit to reschedule a non-emergent office appointment. The deposit will not be refunded if the patient has another late cancellation or no-show. We will continue to provide emergency gastroenterology care and prescription renewals for 60 days without a deposit.
- At the end of the 60 days, if the payment is still not received, a termination of care letter will be sent to the patient advising the patient of discharge from practice. Emergency gastroenterology care will be provided for an additional 30 days from the date of discharge letter.

Revised 7/8/15

- The patient may be admitted back to the practice if the fee is paid after the 60-day "grace period". However the patient must make a $100 deposit for the first office appointment (this requirement is only for those who did not pay fees within 60 days and was discharged). If the patient cannot afford to or unwilling to make the deposit, the patient cannot be admitted back to the practice.

Each patient will be tracked for the number of no-shows and late cancellations. If the number of either or the combination of late cancellations and no-shows exceed three (3) occurrences within any consecutive 12 months, the patient will be discharged from the practice and no further appointments will be scheduled.

Signature _____ *Date* _____

*Print Name*_____ *DOB:*_____

Western Washington Medical Group
Endoscopy Center

Endoscopy Procedure Late Cancellation and No Show Policies

A late cancellation or "no-show" is someone who misses a procedure appointment without canceling it **5 business days in advance** or someone who fails to present at the time of a scheduled procedure without notice. ***The patient will be charged $250.00 for either late cancellations or no shows. The procedure cannot be re-scheduled until the $250.00 charge is paid by the patient.*** Insurance companies will not be billed for this fee.

This agreement applies to endoscopy procedures performed by our providers at WWMG Endoscopy Center, Providence Medical Center, Evergreen Health Monroe, Whidbey General Hospital, and/or Island Hospital.

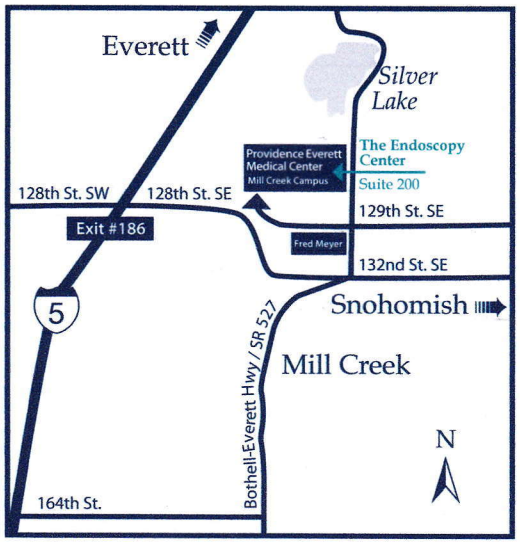
By my signature, I certify that I have read and understand the policy.

Signature _____ Date _____

Print Name _____ DOB: _____

Revised 7/8/15

The Endoscopy Center
12800 Bothell-Everett Highway, Suite 200, Everett



Directions

From I-5 traveling north, take the 128th Street SW exit, (Exit #186). Go right onto 128th Street SE and drive east.

From I-5 traveling south, take the 128th Street SW exit, (Exit #186). At the stoplight go left onto 128th Street SE and drive east.

Follow 128th Street SE past McCollum County Park. 128th St. SE will turn into 132nd St. SE. Turn left on 19th Ave. SE (SR 527) – Fred Meyer will be on the left side of the intersection – and head north for one block.

Turn left at 129th Place SE (stoplight) and go straight ahead. The road will curve to the right, behind Fred Meyer, and lead you directly into the parking lot of Providence Everett Medical Center – Mill Creek campus.

The Endoscopy Center is located in Suite 200, on the 2nd floor, at the top of the stairs.