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 will not be billed 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, Friedrich C. Loura, M.D., Edward A. Slosberg, M.D., James Z. Mu, M.D., and Sujoy 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 centers and 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.

I have read and understand this disclosure statement.

_____ _____

Patient's signature Date

_____

Witness

Western Washington Medical Group
Endoscopy Center

PATIENT RIGHTS AND RESPONSIBIITIES

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

THE RIGHT TO:

- Exercise your rights without fear of discrimination or reprisal.
- 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 Advance 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. Please have a copy with you if available. Advance Directives information can be found at http://www.wwmedgroup.com/
- Express any comments, concerns or grievances regarding the care given 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/claims-and-appeals/medicare-rights/get-help/ombudsman.html or mail your complaints to:

HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98045-7857

Phone: 360-236-4700
Toll Free: 800-633-6828
Fax: 360-236-2626 E-mail: HSQAComplaintIntake@doh.wa.gov

Western Washington Medical Group
Endoscopy Center

FREQUENTLY ASKED COLONOSCOPY PREPARATION QUESTIONS

Please read your 5 day prep planner immediately upon receiving

1. **When is the last time I can have liquids to drink before my prep starts?**
   - You may have clear fluids up until you start drinking your prep, then water only until after your procedure. No purple, blue or red.
2. **Can I start my prep later/earlier?**
   - Yes, but no earlier then 1 hour earlier and no later then 1 hour after start time
3. **If I am clean/clear at night, do I have to drink my morning preparation doses?**
   Yes, follow the **exact** directions on your 5 day prep planner. Overnight your body will re-coat your colon with mucus and bile – the time between the PM and AM doses of prep is set to prevent this build up.
4. **If I vomit, what do I do?**
   - If you vomit only a few times, take a break, lengthen time out between glasses until this resolves. If vomiting is continual and excessive, call the on-call physician.(425)259-3122.
5. **I drank almost all of my prep and still have not gone to the bathroom. What should I do?**
   - During Endoscopy hours, 7am-4pm, call Denise at (425)316-5193 or the GI office for the on-call physician at (425)259-3122.
6. **What happens if my prep is not adequate?**
   - It is very important that you are clean which should occur if you follow the exact 5 day prep planner. This will improve the chance of visualizing colon polyps or abnormalities during your exam. If your prep is not adequate, your procedure may be cancelled and rescheduled or your procedure time will be delayed in order to allow time to drink more prep solution. If the procedure is attempted but aborted due to a poor prep, you may be charged for two procedures.
7. **My family member did a different prep. Can I do the one that they did instead?**
   - No, your prep regime has been prescribed specifically for you by your (the) doctor.
8. **The pharmacist gave me different instructions to follow, a different prep, and/or the instructions on the container of prep are different than my prep planner?**
   - Follow your 5 day prep planner **only.** Do not use any other prep.
9. **What if I do not have a driver or they can not stay for the entire time?**
   - Your procedure will be cancelled if your driver is not in the building at all times. **This is a strict policy.** You have the option of rescheduling your exam. In certain instances the procedure can be done without sedation, though if unsuccessful, you will also be billed for a rescheduled exam.
10. **Will I be knocked out?**
    - You will receive conscious/moderate sedation which consists of a sedative and a narcotic pain reliever. General anesthesia or Propofol is not used at the Endoscopy Center. You may or may not remember the complete procedure.
11. **What if I am on my monthly menses?**
    - This will not affect your procedure in any way.
12. **Should I bring my CPAP machine?**
    - No, you will not need it during this procedure.

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WESTERN WASHINGTON MEDICAL GROUP
DEPARTMENT OF GASTROENTEROLOGY AND ENDOSCOPY

REGISTRATION FORM

ACCOUNT#_____ NEW ____ UPDATE ____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE	SOCIAL SECURITY #

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	LANGUAGE

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

____ SPOUSE	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI

____ PARENT	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

____ GUARDIAN	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.

VOICEMAIL # INITIALS

PATIENT SIGNATURE ***DATE***

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

Western Washington Medical Group
Gastroenterology

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.

A **No-Show Fee** for procedures of $250.00 will be charged if not cancelled a minimum of 72 hours prior to the procedure.

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_____

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

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