



## WELCOME

*We have provided this information in order to make your procedure as easy and comfortable as possible.*

### WHAT IS ENDOSCOPY?

Endoscopy (also known as GI Endoscopy) is a procedure that enables your physician to diagnose and treat digestive diseases by examining the lining of your gastrointestinal tract. Endoscopy is more than x-ray films for detecting inflammation, ulcers, or tumors of the digestive tract. Upper Endoscopy, often called Esophagogastroduodenoscopy (EGD) or Panendoscopy, focuses on the upper part of the digestive tract. Lower Endoscopy, often called Colonoscopy, examines the large intestine.

### WHY ARE ENDOSCOPIES DONE?

Upper endoscopies are usually performed to evaluate symptoms of upper abdominal pain, nausea, vomiting, or difficulty swallowing. It is also the best test for finding the cause of bleeding from the upper gastrointestinal tract. Similarly, lower endoscopies help determine the cause of bleeding from the lower digestive tract. Lower endoscopies are also performed to screen for colorectal cancer and to evaluate symptoms of lower abdominal pain and persistent diarrhea.

### PREPARING FOR YOUR PROCEDURE

If your Endoscopy is scheduled in the morning, do not eat or drink anything after midnight the evening before the procedure, unless instructed otherwise by your physician.

If your Endoscopy is scheduled in the afternoon, be sure to ask your physician the time you are to stop eating or drinking the morning of your procedure.

**Medications should be taken at the recommendation of your physician. If you are taking any medications for your heart, blood pressure, breathing, or for diabetes, be sure to ask your physician if you are to take any of them the day of your procedure.**

Notify the Center and the physician's office if you should become ill prior to your procedure.

Desert Endoscopy Center is not responsible for lost items. Therefore, leave all items you consider to be valuable, such as jewelry, watches, rings, earrings, wallets, purses, cell phones etc., at home or with the responsible adult who will be driving you home.

### YOUR PROCEDURE

Your procedure is scheduled on \_\_\_\_\_ at \_\_\_\_\_ am/pm. It is essential that you arrive no later than \_\_\_\_\_ am/pm. The nurses at Desert Endoscopy Center

need time to admit you and get you prepped prior to your procedure. **If your physician gave you a registration packet for Desert Endoscopy Center, please complete it and bring it in with you at the time of your procedure. You may also print a copy of your registration packet by going to [www.desertendoscopy.com](http://www.desertendoscopy.com) and clicking on For Your Visit/Download Forms.**

Your physician's office provided you a copy of your Patient's Bill of Rights and Responsibilities. **You must read this in advance of the day of your procedure.**

**If you have any Advanced Directives, such as a Living Will or Power of Attorney, you will need to bring a copy of it with you at the time of your procedure.**

You will be given medication to make you more comfortable during your procedure. Therefore, you will not be able to drive or return to work that day. This is for your safety. **You must have a responsible adult to drive you home or accompany you home after your procedure. This can be family, friend, or medical transport, not regular taxi, Uber, or Lyft, etc.**

After your procedure, you will remain in the recovery room until you are ready for dismissal. Your approximate stay at the Center may range from 1-2 hours, without complications.

Instructions following the procedure will be given at the time you are discharged from the Center. It is important that you follow these instructions and call your physician if you have any problems following the procedure.

### INSURANCE AND BILLING

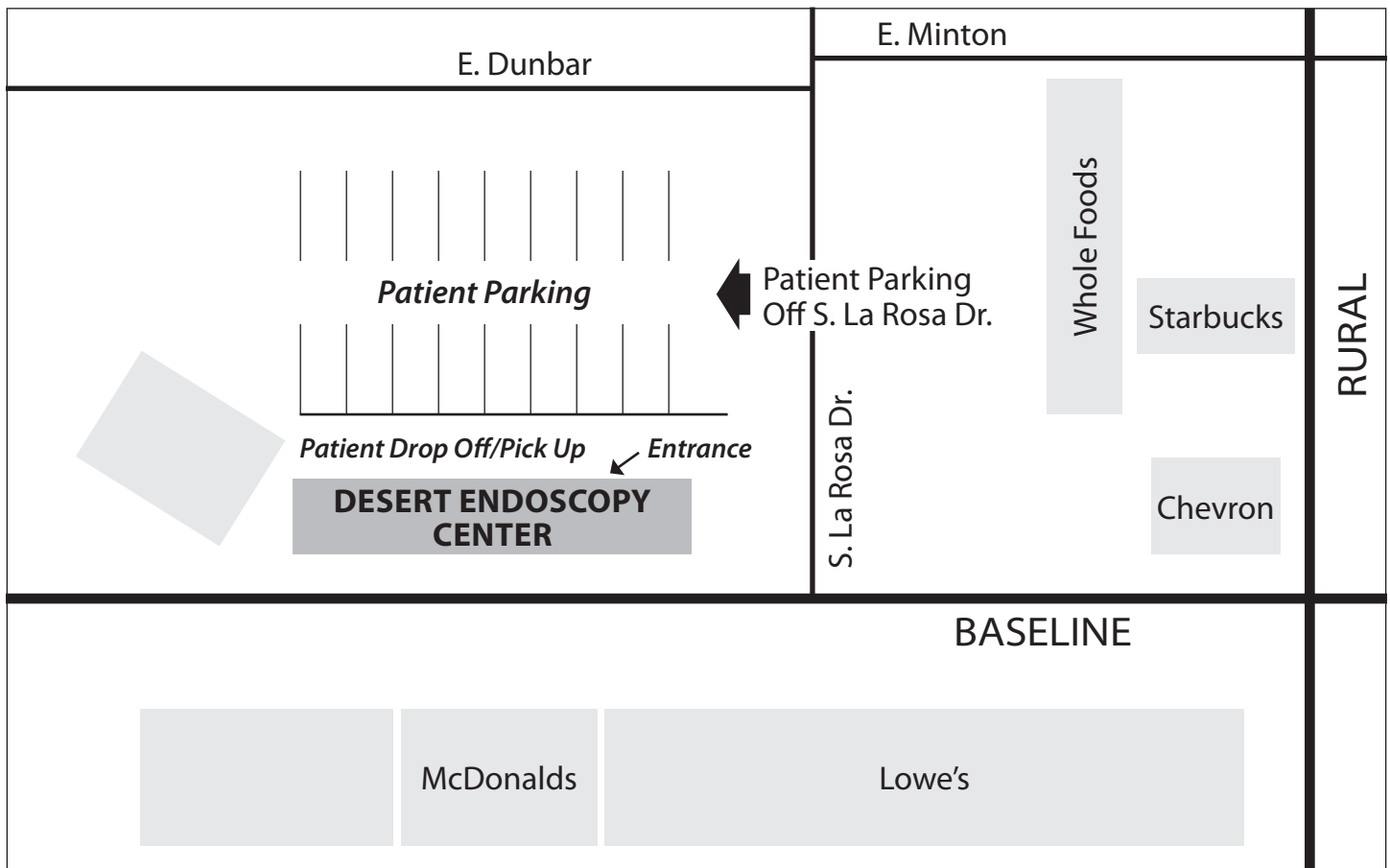
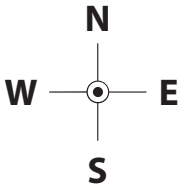
**Please be sure to bring your insurance cards and picture ID with you. Desert Endoscopy Center will bill your insurance as a courtesy; however, payment of co-pays/deductibles/co-insurance is expected at the time of service.** Any balance due on your account after insurance pays is the patient's responsibility and should be paid promptly. Self-pay patients are required to pay the amount in full at the time of service.

As our patient, you are our most valued asset. We appreciate any comments and concerns you may have. If any questions arise, please do not hesitate to bring them to our attention. It is our goal to provide you the very best care available. Thank you for scheduling your procedure at **Desert Endoscopy Center.**

SEE REVERSE SIDE FOR OFFICE LOCATION

## LOCATION

Between Rural and S. College Avenue in Tempe  
on North side of Baseline Road across from the Lowes and McDonalds.  
Just West of the Whole Foods Shopping Center.  
Turn North on S. La Rosa Drive.  
Entrance is on East side of the building.



# PATIENT REGISTRATION FORM

PLEASE USE BLACK INK

PLEASE PRINT CLEARLY



_____		_____		_____
Last Name		First Name		M.I.
_____		_____	_____	_____
Billing Address		Apt #	City	State Zip
(____) _____ - _____	(____) _____ - _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Phone	Mobile Phone			
____ / ____ / ____	____ - ____ - ____	_____	_____	
Date Of Birth	Social Security Number	Marital Status	Name of Spouse	
_____		(____) _____ - _____	_____	
Name of Employer		Employer Phone		
_____		_____		
Email Address		Family Care Physician		

## MEDICAL INSURANCE INFORMATION

It is your responsibility to tell us in advance if your insurance company requires pre-certification of procedures. Please keep us informed of changes in your insurance. Claims will be filed for you.

### PRIMARY INSURANCE

### SECONDARY INSURANCE

Name of Insurance: _____	Name of Insurance: _____
ID or Policy Number: _____	ID or Policy Number: _____
Group Number: _____	Group Number: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Address: _____	Policy Holder's Address: _____
Policy Holder's Birth Date: _____	Policy Holder's Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____

I hereby acknowledge that the information provided above is correct.

_____	_____
Patient's Signature	Date

# MEDICAL HISTORY QUESTIONNAIRE

Please complete **both sides** of this form **prior** to arrival to expedite your admission process.



\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.I.

## Scheduled Endoscopy Procedure(s)

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> EGD (upper Endoscopy) | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Sigmoidoscopy |
| <input type="checkbox"/> Enteroscopy           | <input type="checkbox"/> Ileoscopy   | <input type="checkbox"/> Other _____   |

**Reason for Procedure(s)**     Screening only (*no symptoms*)

Personal history of

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Colon polyps       | <input type="checkbox"/> Colon cancer        | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Crohn's Disease    | <input type="checkbox"/> Barrett's esophagus | <input type="checkbox"/> Recent Ulcer       |
| <input type="checkbox"/> Esophageal varices |  |   |

## Symptoms

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Nausea  | <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Vomiting blood                |
| <input type="checkbox"/> Trouble swallowing  | <input type="checkbox"/> Painful swallowing | <input type="checkbox"/> Heartburn                     |
| <input type="checkbox"/> Acid reflux   | <input type="checkbox"/> Bloating/Gas       | <input type="checkbox"/> Constipation                  |
| <input type="checkbox"/> Stool incontinence  | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Bloody diarrhea               |
| <input type="checkbox"/> Blood in stool  | <input type="checkbox"/> Trace bleeding     | <input type="checkbox"/> Black stools                  |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Bleeding with bowel movements |
| <input type="checkbox"/> Change in bowel pattern: Describe (from what to what) _____   |   |  |
| <input type="checkbox"/> Abdominal pain: Location (right, left, upper, lower, center, etc.) _____  |   |  |
| <input type="checkbox"/> Finding on: <input type="checkbox"/> Ultrasound <input type="checkbox"/> CT scan <input type="checkbox"/> Barium study <input type="checkbox"/> Other _____ |   |  |

## Family History of:

- |   |                                       |            |                          |
|---|---------------------------------------|------------|--------------------------|
| <input type="checkbox"/> Colon cancer                   | <input type="checkbox"/> Colon polyps | Who: _____ | Age when diagnosed _____ |
| <input type="checkbox"/> Other reason not listed: _____ |                                       |            |                          |

**Past Endoscopy Procedures** (type, date, physician) \_\_\_\_\_

**Allergies** to medications or other substances:     Latex     \_\_\_\_\_

**Current Medications** List name, dose, and frequency (twice a day, 3 times a week, etc.) Include over the counter and herbal medications.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you are currently taking any **blood thinners**, including over the counter aspirins or anti-inflammatory medications, it is necessary for you to determine **if** and **how long** they are to be discontinued, prior to your procedure, by discussing it with your physician, at the time you are scheduled. If you have not done so, please contact your physician's office for clarification.

If you are currently taking medication to control Diabetes, either **insulin** or **pill form**, it is necessary for you to determine how to manage your medication the day before and the day of your procedure, by discussing it with your physician, at the time you are scheduled. If you have not done so, please contact your physician's office for clarification.

Current weight: \_\_\_\_\_

**Past Medical History** (please describe)

- Cardiovascular disorder: \_\_\_\_\_
- High Blood Pressure                       Endocarditis                       Heart valve disorder
- Pulmonary disorder: \_\_\_\_\_
- Neurological disorder: \_\_\_\_\_
- Endocrine disorder: \_\_\_\_\_
- Diabetes: (insulin?) \_\_\_\_\_
- Liver disorder: \_\_\_\_\_
- Bleeding disorder: \_\_\_\_\_
- Cancer: \_\_\_\_\_
- Renal disorder: \_\_\_\_\_
- Musculoskeletal disorder: \_\_\_\_\_
- Other: \_\_\_\_\_

**Females**

- LMP date: \_\_\_\_\_  Post Menopausal/Sterile     Currently pregnant     Breastfeeding

**Prosthesis / Implants**

- Artificial heart valve     Pacemaker     Automatic internal cardiac defibrillator
- Artificial joint replacement: Location \_\_\_\_\_
- Orthopedic implants: Location (pins, rods, screws, plates) \_\_\_\_\_
- Other implants: (type and location) \_\_\_\_\_
- Prosthetic devices: (type and location) \_\_\_\_\_

**Past Surgeries / Hospital Procedures:** List year and type of occurrence

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**Adverse Reactions** to any prior anesthesia/sedation: (please describe) \_\_\_\_\_

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If there has been any **significant** change in your medical history, since your last office visit, it is necessary for you to contact your physician's office to update your physician with this information, **prior** to your visit to our facility.

Please complete both sides of this form

## EXPLANATION OF BILL

The total cost of your medical services may be comprised of up to five (5) fees, since the provider of each service bills each fee separately.

1. You will receive a statement from **Desert Endoscopy Center**, which covers the cost of providing the facility, technicians, nurses, equipment, and supplies involved in the performance of your services. Co-pays, deductibles, and co-insurances will be collected at the time of service. However, this is only an estimation of your patient responsibility. If there is a balance after your insurance pays, you will receive a statement for that amount. Please make arrangements to pay the portion that is not covered by your insurance when you receive your statement. For your convenience, we accept all major credit cards, Care Credit, check, and cash. If you do not have insurance and are a self-pay patient, you must contact the billing office to make payment arrangements prior to your procedure. For billing questions, please contact us at 480-969-0405 extension 211 or extension 225.
2. You will receive a statement from your **Endoscopy Physician** for professional fees that include performing the Endoscopy procedure, supervising, interpreting, and consulting with you and your referring physician. For billing questions pertaining to this service, please call your physician's office.
3. You may receive a statement from a **Pathology/Laboratory service** for the interpretation of any specimens (biopsies, polyps, brushings, and stool specimens) that may have been collected during your procedure. For billing questions pertaining to these services, please call the phone number located on your bill.
4. You may receive a separate statement from **DEC Anesthesia LLC** for services provided by the Certified Registered Nurse Anesthetist and a separate statement from **Grand Canyon Anesthesiology Consultants** for supervising your anesthesia services during your care at the center. Please be advised that while best efforts will be made to provide in-network services, some charges may be processed as out-of-network by your insurance company. For billing questions for these services, please call 602-343-2900.

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Patient's Signature

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Date

## AUTHORIZATION FORM

### FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Desert Endoscopy Center (DEC) (the Facility) charges, the facility is authorized to submit a claim for payment to my insurance carrier. The Facility is not obligated to do so, unless under contract with the insurer or bound by a regulation of a State/Federal agency, to process such claim. DEC expects payment of co-pays/deductibles/co-insurance at the time of service. Self-pay patients are required to pay the amount in full at the time of service. There will be a \$25.00 fee charged to our account for an checks returned for insufficient funds.

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to DEC for services rendered. I guarantee prompt payment of all charges incurred, balances due after insurance payments are made, and charges not paid within a reasonable period of time by my insurance or third party payer. I certify that the information given regarding insurance information coverage is correct.

### COLLECTIONS NOTICE

Patient and/or guarantor agrees to pay all cost of collections including attorney fees, collection fees, and contingent fees to collection agencies of not less than 32% of the delinquent balance, such contingency fee will be added and collected by the collection agency immediately upon our referral of your account to the collections agency of our choice.

### RELEASE OF MEDICAL RECORDS

I authorize the Center rendering service to release all or part of my medical records where required/permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

### DISCLOSURE OF OWNERSHIP NOTICE

I have been informed that the physician who is rendering service to me may have an ownership interest in this facility. DEC is making this disclosure in accordance with federal regulations.

### PATIENT RIGHTS AND RESPONSIBILITIES

I hereby acknowledge that I received verbal and written information regarding the Patient's Bill of Rights and Responsibilities prior to my procedure.

### CERTIFICATION OF PATIENT INFORMATION

I reviewed my patient demographic and insurance information on this date and verify that all information reported is correct.

### PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize DEC and/or the physician performing my procedure today to communicate information regarding my procedure/ results of my procedure/billing information to:

- My spouse/family member/other Name(s): \_\_\_\_\_ Initials \_\_\_\_\_
- Leave a voice mail or message:  Yes  No Initials \_\_\_\_\_

### ADVANCE DIRECTIVES

- I have an Advanced Directive:  Yes  No  Copy Provided
- I would like more information about Advanced Directives  Yes  No  Information Provided

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Relationship to Patient

## SCREENING DISCLOSURE

Colorectal cancer is largely preventable through screening, which can find colon polyps that can be removed before they turn into cancer. Screening can also detect cancer early when it is easier to treat and cure.

The frequency of screening is based on an individual's risk for Colorectal cancer and the type of screening test that is used. Limiting screening to only these high-risk groups would miss the majority of colorectal cancers, thus screening is recommended for all adults age 50 and older.

Your health plan may include a screening benefit. However, should the result of your procedure reveal abnormal findings, your procedure will be filed with your insurance company as a *diagnostic procedure* (not a screening colonoscopy). This may result in applicable deductibles and/or coinsurance responsibility on your part.

I have read and understand that I may be responsible for resulting coinsurance and deductibles according to my plan benefits.

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Signed

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Date

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Witnessed

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Date



# NOTICE OF PRIVACY PRACTICES

*This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.*



## **Patient Health Information**

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

## **How We Use Your Patient Health Information**

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

## **Examples of Treatment, Payment, and Health Care Operations**

**Treatment:** We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

**Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

**Health Care Operations:** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

## **Special Uses**

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

## **Other Uses and Disclosures**

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

**Required by Law:** We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

**Research:** We may use or disclose information for approved medical research.

**Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

**Health oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

**Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena or court order.

**Law enforcement purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.

**Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

**Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

**Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, unless otherwise permitted by law, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

## **Individual Rights**

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

**Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.

**Confidential Communications:** You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

**Inspect and Obtain Copies:** In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

**Amend Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

**Accounting Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

**Notification of Breach:** You have the right to be notified in the event we discover that a "breach" of your unsecured protected health information has occurred. In that circumstance, we will notify you promptly with the necessary information.

## **Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

## **Changes in Privacy Practices**

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice on our website, in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

## **Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

## **Contact Person**

If you have any questions, requests, or complaints, please contact: Administrator-Rose Ellertson, RN

**Effective Date:** September 23, 2013

I, \_\_\_\_\_,  
hereby acknowledge receipt of the Notice of Privacy Practices given to me.  
Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed, reason why acknowledgement was not obtained: \_\_\_\_\_

Staff Witness seeking acknowledgement

\_\_\_\_\_ Date: \_\_\_\_\_