GATEWAY GASTROENTEROLOGY INC.

Office: (314) 529-4900
Exchange: (855) 224-7875
Fax: (314) 434-2679
www.gatewaygi.com

Jeffrey Mathews, M.D.
Brian McMorrow, M.D.
Rajeev Ramgopal, M.D.
Richard Riegel, M.D.
Jonathan Seccombe, M.D.
Andrew Su, M.D.
Fred Williams, M.D.
Amelia Aubuchon, F.N.P.
Cheri Carmody, A.N.P.
Kaitlin Doneff, A.G.N.P.
Tracy Smith, A.G.N.P.

Colonoscopy Preparation Instructions

Your procedure is scheduled for _____ at _____.

Please call the office or if after hours the physician on-call if you feel the prep is not adequately preparing you for the colonoscopy. Please call our exchange at 855-224-7875, press option 3 for an urgent issue to speak with on-call provider.

Your procedure will be performed at the facility below. Please note, this is **NOT** our office location.

Gateway Endoscopy Center
12855 North Forty Drive
South Tower, Suite 150
St. Louis, MO 63141
314-336-1130

Please arrive 1 hour prior to your appointment time.

For patient coming from the east (traveling west on US 40):

- Exit US 40 at Mason Road (Exit 24).
- Immediately upon exiting onto Mason Road, make a quick right onto North Forty Drive.
- The Walker Medical Building will be approximately ½ mile on the left. (The building is located between Lutheran Hour Ministries and CBC High School.)
- Enter the South Tower, Suite 150 is on the first floor.

For patient coming from the west (traveling east on US 40):

- Exit US 40 at Mason Road (Exit 24).
- Go to the stoplight at Mason Road and turn left.
- Go across the bridge over US 40 and immediately turn right on North Forty Drive.
- The Walker Medical Building will be approximately ½ mile on the left. (The building is located between Lutheran Hour Ministries and CBC High School.)
- Enter the South Tower, Suite 150 is on the first floor.

If you cannot keep your scheduled appointment, please notify us at least **2 business days** before your scheduled time.

PLEASE REVIEW THE "SPECIAL CIRCUMSTANCES" SECTION ON THIS DOCUMENT CAREFULLY TO SEE IF YOU REQUIRE SPECIAL INSTRUCTIONS OR MODIFICATIONS.

BOWEL PREPARATION:

Necessary items to purchase:

- SUPREP Bowel Prep Kit - This prep requires a prescription which has been provided. There is a coupon available at www.suprepkit.com. This coupon can only be used for non-Medicare patients. If you find that the prep is too expensive, please contact our office for an alternative preparation. **Please take this script to your pharmacy 1 week prior to your scheduled appointment as to not cause any delays in getting your script.**
- **Disregard** instruction on the SuPrep Kit as we have altered the prep based on our clinical experience, for your safety.

5 days prior to your procedure – avoid seeds and nuts as much as possible.

The day prior to your procedure:

- **NO SOLID FOODS All Day Long!!** Consume only clear liquids on this day. Examples: water, any kind of soda, Gatorade, black coffee, tea, popsicles, Jell-O, broth, bouillon, and fruit juices that you can see through (apple, white grape and white cranberry are OK, orange and tomato are not). **NO Red or Purple products should be consumed.**
- **Drink a lot of clear liquids throughout the day and evening.**
- **AFTER MIDNIGHT NOTHING MORE EXCEPT FOR THE PREP AS DIRECTED.**
- No alcohol allowed on the day of the prep and the day of the procedure.

**** Prior to Starting the Prep, make note of the time your procedure is scheduled, not your arrival time.****
What time is your procedure? _____

WHEN TO START

If your procedure is …

- At or Before 11:00am — Start PART A at 4pm the afternoon before your procedure.
  Start PART B at 11pm the evening before your procedure.
- After 11:00am — Start PART A at 6PM evening before the procedure
  Start PART B at 6AM the morning of the procedure

PREP PART A (Complete all 4 steps within 90 minutes)

- **STEP 1 –** pour **ONE** 6 oz. bottle of SUPREP liquid into the mixing container. Then fill the container to the 16-ounce line with cold water.
- **STEP 2 - DRINK ALL THE LIQUID IN THE CONTAINER** within 20 minutes.
- **STEP 3 -** Twenty minutes after finishing Step 2, fill the container with water (16 oz.) and drink it.
- **STEP 4 -** Fill the container with 16 oz. of water and drink it.

You may continue to drink additional clear liquids if you wish until midnight. Then nothing more except for the portions of the prep as directed.

PREP PART B

- **Repeat steps 1, 2, 3 and 4 above.**

***** AFTER FINISHING PREP PART B – DO NOT EAT OR DRINK ANYTHING ELSE.*****
You need to finish the Prep at least 4 hours before the scheduled start of the procedure. If you consume additional liquids it can increase the risk of respiratory complications from the procedure and sedation.

- Complete the enclosed forms and bring them with you the day of your procedure, along with your insurance cards and picture ID.
- If your bottom is sore, try an ointment such as A&D ointment, Preparation H, or Vaseline to the anal area as needed.

The day of the procedure:

- If you are a smoker, please do not smoke the day of your procedure. This includes e-cigarettes, cigars, cigarettes, pipe, and marijuana.
- You may take your usual medications with sips of water as early as possible the day of the procedure.
- Arrive at Gateway Endoscopy Center 1 hour prior to your scheduled procedure time.
- **SOMEONE WILL NEED TO DRIVE YOU TO AND FROM THE CENTER.**
    - You and your driver can plan to be at the center approximately 2 hours total.
    - You will not be able to drive or drink alcohol the rest of the day.
- If you have any questions, the nurse will go over it with you at the time of your appointment.
- All Female Patients: If you are between the ages of 12-49, you will be required to give a urine specimen unless you have had a Hysterectomy or Tubal Ligation.
- Please bring with you:
    - ✓ Insurance cards
    - ✓ Picture ID
    - ✓ Completed patient information form
    - ✓ Completed patient history form
    - ✓ Completed medication reconciliation form
    - ✓ Financial disclosure and agreement

SPECIAL INSTRUCTIONS:

Patient with an implantable defibrillator and/or pacemaker: Please call us at least five (5) days before the procedure for instructions.

If you have had a cardiac stent placed in the last 12 months or if you are taking an anti-platelet medication with aspirin, please contact our office at 314-529-4900 to discuss.

Coumadin, Jantoven (warfarin), Arixtra (fondaparinux): Call your prescribing physician and ask if you can safely stop this medication **four (4) days** before the procedure. If your doctor tells you that you cannot stop the Coumadin, then please call us immediately to make us aware of this. We will then discuss with you the various options available.

If you take **Eliquis (apixaban), Fragmin (dalteparin), Iprivask (desirudin), Lovenox (enoxaparin) Pradaxa (dabigatran) or Xarelto (rivaroxaban):** Call your prescribing physician and ask if you can safely stop these medications **2 days** before your procedure. If your doctor tells you that you cannot stop these medications, please call us immediately to make us aware of this. We will then discuss with you the various options available.

Plavix (clopidogrel), Brilinta (ticagrelor), or Effient (prasugrel): If you are taking any of these medications **WITH Aspirin,** please call our office at 314-529-4900 to discuss. If you are taking any of these 3 medications **without Aspirin,** it is not necessary to stop them prior to your procedure.

Iron: Stop iron four (4) days before the procedure. Iron can make preparation difficult and result in a poorly cleaned colon.

Antibiotics for procedures: Recent publication from both the American Heart Association and American Society for Gastrointestinal Endoscopy state that antibiotics are not necessary for routine endoscopic procedures.

Insulin: Call your prescribing physician at least five (5) days before the procedure and ask for instructions.

Herbal Medications: It is best to stop any herbal remedies five (5) days before the procedure as many of them can thin the blood and increase risk of bleeding during the procedure.

Additional Information:
Approximately 3 business days prior to your procedure, you will be receiving a phone call reminding you of your appointment. If you are not home, a message will be left on your answering machine/voicemail. Unless you want to cancel or reschedule your appointment, it is not necessary to call the office to confirm. We will assume you are keeping your scheduled appointment unless we hear from you.

We also suggest that you contact your insurance to verify coverage for colonoscopy. Some insurance plans cover colonoscopy for colon cancer screening or routine/preventative care. Other plans only cover colonoscopy if you are having symptoms or they may say it's covered only if "medically necessary". There are many different insurance companies and each individual plan is different.

You may visit our website (www.gatewaygi.com) for more detailed information regarding the physician you will be seeing and other services offered.

PATIENT PORTAL

Gateway Gastroenterology has a Patient Portal for you to access some of your information. This portal shows any upcoming or previous appointments and you can also securely communicate with our office for questions to the doctor, nurse practitioner or staff.

You will get access to the Patient Portal once we have obtained your email address and have entered it into our practice management system. You will receive an email once we have enabled you to continue the registration process.

The web address: https://health.healow.com/gatewaygi

Please bookmark or save this to your Favorites.

At this time the portal does not show your medications or any results.

Gateway Gastroenterology Website

Any paperwork that you may have done on our website, only pertains to our office and it does not meet the necessary paperwork requirements for the facility where your procedure is being performed. The facility is a separate entity and has a separate medical record for you. You will need to fill out the following paperwork and bring it with you to your procedure.

Colonoscopy: Screening or Diagnostic?

Your insurance policy may be written with different levels of benefits for preventative versus diagnostic or therapeutic colonoscopy services. This means that there are instances in which you may think your procedure will be billed as a "screening" when it actually has to be billed as diagnostic/therapeutic.

How can you determine what category your colonoscopy falls into?

Colonoscopy Categories: Diagnostic/therapeutic colonoscopy:

Patient has **past** and/or **present** gastrointestinal symptoms, personal history of **polyps,** GI Disease (UC or Crohn's), iron deficiency anemia and/or any other abnormal tests.

Preventative Colonoscopy with Screening Diagnosis: Patient is **asymptomatic** (no gastrointestinal symptoms either past or present, over the age of 50, has no personal history of GI disease (UC or Crohn's), colon polyps, and/or cancer. (The patient has not undergone a colonoscopy within the last 10 years.)

Before your procedure, you should know your colonoscopy category. After establishing which one applies to you, you can do some research with your insurance company regarding your coverage and what your out of pocket expense will be.

Your primary care physician may refer you for a "screening" colonoscopy, but there may be a misunderstanding of the word "screening." You must have no symptoms at all for your colonoscopy to be billed as a screening service.

Can the physician change, add or delete my diagnosis so that I can be considered eligible for a colon screening?

NO! The physician encounter is documented in your medical record from information you have provided as well as what is obtained during our pre-procedure history and assessment. It is a binding and legal document that cannot be changed to facilitate better insurance coverage. Patients need to understand that strict government and insurance company determination and coding guidelines prevent a physician from altering a chart or bill for the sole purpose of coverage determination. This is considered fraud and punishable by law with fines and/or jail time.

What if my insurance company tells me that a doctor can change, add, or delete a CPT or diagnosis code?

Sadly, this happens a lot. Often the representative will tell the patient that "if the doctor had coded this as screening, it would have been covered differently." However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if applicable to the patient. Remember that most insurance companies only consider a patient over the age of 50 with no past and present symptoms as "screening." If you are given this information, please document the representative's name and date so we can report them to our insurance representative.

Please acknowledge receipt of this document by signing below and bringing it with you to your appointment.

_____

Patient Signature Date

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Tracy Smith. A.G.N.P.

Welcome

Dear Patient:

Welcome to Gateway Gastroenterology and Gateway Endoscopy Center! We look forward to meeting you. We'd like to take this opportunity to tell you a little about us.

Gateway Gastroenterology is a group of board-certified gastroenterologists that was established in 1984. Our areas of expertise include the esophagus, stomach, small intestine, colon, liver, gallbladder, and pancreas. We offer a wide variety of gastroenterology services including inpatient and outpatient consultation as well as a broad range of endoscopic procedures.

Gateway Endoscopy Center is an outpatient ambulatory surgery center where the physicians from Gateway Gastroenterology perform upper endoscopy and colonoscopy procedures. The facility is open Monday through Saturday. After hours and emergency care is provided through the physicians' office and exchange.

We look forward to assisting you.

Sincerely.

Gateway Gastroenterology

Gateway Endoscopy Center

How did you hear about our practice (please circle): Primary Care MD OB/GYN Internet Friend/Family Advertisement Other: _____

Name:_____ Sex: Male/Female Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Agree to Receiving Text Message from the Practice: (Please Circle) Yes No

Social Security #: ____ _____ Marital Status: _____ Spouse's Name: _____

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Referring Physician: _____

The following is required by the State of Missouri (please circle) Hispanic or Latino Neither Hispanic nor Latino

Race: (Please circle) White Black or African American American Indian Alaska Native Asian Native Hawaiian/Pacific island Other not listed Multi-Racial (two or more races) Choose not to answer

Language Spoken: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: _____

Policy/Id#: _____ Group#: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

Secondary Insurance Company: _____ Phone Number: _____

Policy/Id#: _____ Group#: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

Policy Holder Info (if other than patient)

Name: Mr/Mrs/Ms _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ Relationship to patient: _____

Best Contact Phone #: _____ Employer: _____

Responsible Party/Guarantor's signature: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BEFEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

By providing the information I agree that Gateway Gastroenterology, Inc., or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, leave a voice message on an answering device, send mail to my home address, or email notification regarding my care, our services, or my financial obligation. I hereby authorize the release of any medical information necessary to process my health insurance claims. I permit a copy of this authorization to be in place of the original. I have received a copy of Notice of Privacy Practices.

_____

Signature Date

Gateway Endoscopy Center – Medication Reconciliation Form

Name: _____ **Date of Birth: _____**

Pharmacy Name: _____ **Pharmacy Phone: _____**

Allergies (food, medications, latex, etc.)

Medication Name	Reaction	Medication Name	Reaction

- List **ALL YOUR MEDICATIONS** including, **eye drops**, **over-the-counter** and **alternative medicines** such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety, that you provide complete and accurate information.
- Please let your nurse know if you do not remember all of the medications that you take.

Medication List

Medication Name	Dose	How often do you take it?	Why are you taking this medication?	Last dose taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

It is suggested that you provide a copy of this list to your Primary Care Provider.

OFFICE USE ONLY

Reviewed by RN _____
Signature Date/Time

☐ No changes to Medications; Resume home Medications
☐ Changes

New Medication Name	Dose	Frequency	Purpose of Medication

☐ Patient education regarding medication changes

Medications Reconciled by RN _____
Signature Date/Time

Gateway Endoscopy Center and its providers are not responsible for medications ordered by other organizations or providers.

Gateway Endoscopy Center
Patient History Form

Name_____ DOB_____ Referred By:_____

Single ____ Married ____ Divorced ____ Separated ____ Widowed ____ Advanced Directive Y/N

Retired ____ Occupation _____ # of Children _____

Driver's Name _____ Driver's Phone # _____

Current Symptoms:
Difficulty Swallowing
Heartburn/Indigestion
Sore Throat
Loss of Appetite
Nausea/Vomiting
Gas/Bloating
Abdominal Pain
Recent Weight Change
Change in Bowel Movements
Diarrhea
Constipation
Rectal Bleeding

Smoking: Y/N
_____ pk/yrs
_____ yr quit

Alcohol: Y/N
_____/day
_____yr quit

Recreation drugs
Y/N
Type:_____

Family History of Colon Cancer? Y/N
If yes, who?_____

Family History of Polyps? Y/N
If yes, who?_____

Last Colonoscopy
Year? _____ **> 3 yrs**_____
Polyps _____
Last Upper Endoscopy
Year? _____

Surgeries:

_____

_____

_____

_____

_____

Personal Medical History
GERD
Barrett's Esophagus
Schatzki's Ring
Hiatal Hernia
Esophageal Cancer
Stomach Cancer
Ulcers
Celiac Sprue
Pancreatitis
Liver Disease
Colon Polyps/Colon Cancer
Diverticulosis/Diverticulitis
Crohn's
Ulcerative Colitis
Heart Disease/Stents
CHF
High Blood Pressure
Stroke
Diabetes
Kidney Problems
Asthma
COPD
Anemia
Seizures
Migraines
Sleep Apnea
Hearing Loss
Cancer _____

Do you have pain now or have you had pain in the last several weeks? Y/N If yes, rate level of pain on a scale of 1-10 with 10 being the worst._____Describe the pain: Where is it located? _____
What aggravates it?_____
How long does it last? _____

Prior Problems with anesthesia? _____
If yes, please describe_____

Do you have any physical, psychological, or emotional needs?
_____

Are you able to perform activities of daily living without assistance?
_____

Reason for Procedure: -
_____

Patient's Signature:_____ Date:_____

Nurse's Signature:_____ Date:_____

Patient's Communication Preferences Regarding Person Health Information

Telephone Communications Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Gateway Gastroenterology/Gateway Endoscopy Center or one of its legal agents, or affiliates may use the telephone numbers provided to send me a text notification call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Gateway Gastroenterology/Gateway Endoscopy Center or one of its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you may receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Gateway Gastroenterology/Gateway Endoscopy Center when your mobile number changes. You are not required to authorize the use of text messages and a decision not to sign this portion of the authorization will not affect your health care in any way.

Mail Communication Preferences
May we send mail to your home address? If no, please provide address _____

Other than you, your insurance company, and health care providers involved in your care, whom we talk with about your health care information? (Check all that apply)

	Name:	**Telephone:**
Spouse	_____	_____
Caretaker	_____	_____
Child	_____	_____
Parent	_____	_____
Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

X _____ _____

Patient or Personal Representative Signature **Date**

NOTICE

Anyone having concerns about the quality of care provide at Gateway Endoscopy Center may report these concerns to the organization's Administrator, the Missouri Department of Health and Senior services, the Accreditation Association for Ambulatory Health Care, Inc., the Medicare Beneficiary Ombudsman. You may choose to report anonymously or provide your name and contact information.

Facility Administrator

Linda Beaver, RN, MSN, MHA
(314) 336-1130 lbeaver@uspi.com

Missouri Department of Health and Senior Services
Bureau of Ambulatory Care

P.O. Box 570
Jefferson City, MO 65102-0570
(573) 751-1588
Fax (573) 751-6648
You may also fill out a concern form online at complaint@dhss.mo.gov

Accreditation Association for Ambulatory Health Care, Inc.

5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847) 853-6060
complaints@aaahc.org

Medicare Beneficiary Ombudsman

www.medicare.gov
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
(800) 633-4227

Gateway Endoscopy Center

PATIENT RIGHTS

- Every patient has the right to be treated fairly, with respect and as an individual.
- Patients are treated with respect, consideration, and dignity. Patients are provided appropriate privacy.
- Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse of their release.
- Patient are informed of their rights to formulate an advanced directive, at the time the procedure is scheduled, permitted by law. This facility does not honor advance directives and the patient has the right to schedule their procedure at another facility.
- Patient are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis.
- 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.
- Patients are given the opportunity to participate in decisions involving their healthcare, except when such participation is contraindicated for medical reasons.
- Patients are provided information about treatment alternatives and will be advised of the advantages and disadvantages of each.
- Patients have the right to refuse to participate in experimental research.
- The patient has the right to be free from all forms of abuse or harassment.
- Patients have the right to know in advance the type and expected cost of treatment.
- Dr. Mathews, Dr. McMorrow, Dr. Ramgopal, Dr. Riegel, Dr. Seccombe, Dr. Su, and Dr. Williams have ownership interest in this facility. You are free to choose another facility or provider in which to receive services. You were informed both in writing and verbally prior to your procedure.
- Patients have the right to be informed of the professional rules, law and ethics that govern the organization and its employees.
- Patients and families have the right to express grievances and suggestions to the organization. Every effort will be made to follow up on all grievances and suggestions. Patient care and satisfaction are very important to our entire staff.

PATIENT RESPONSIBILITY AND CONDUCT

- To provide healthcare providers with complete and accurate information about their health, any medications taken, including over the counter and dietary supplements, and any allergies or sensitivities.
- To ask questions if they do not understand instructions or explanations given by the healthcare providers and/or staff.
- To keep appointments as scheduled and to telephone the office in case of a cancellation.
- To follow healthcare providers instructions and plan of treatment and participate in their care.
- To provide the name of a responsible adult or transportation service who will transport the patient home following their procedure.
- To make payments for services rendered if a balance remains after insurance pays.
- To discuss consequences of refusing treatment or not adhering to plan of treatment or leaving Against Medical Advice (AMA) with their physician.
- To refuse to participate in experimental research, if this is their desire.
- To refuse to allow care from a student or trainee, if that is their desire.
- To behave respectfully toward all health care professionals and staff, as well as other patients and visitors.

Financial Disclosure and Agreement

There are separate service components for which you will be billed separately:

1. Gateway Gastroenterology will bill for the Physician's Professional Charge and for the Anesthesia charges. This billing is for the physician's professional services that are provided during the procedure and the anesthesia used.
2. Gateway Endoscopy Center (GEC), the facility, will bill a fee based on the type and number of procedures being performed. The charges will be billed under Mason Ridge Surgery Center LP. When calling your insurance to verify benefits use Tax Id# 20-5953364 or NPI# 1821453796.
3. Laboratory and Pathology Charge. If you have a biopsy done or polyp(s) removed, you will receive a bill from the laboratory that processed your pathology. In some cases, the laboratory and pathology charges will be billed by Gateway Gastroenterology.

Payment made to the center (GEC) on the day of service are credited towards the facility (GEC) charge only.

I agree to pay GEC in accordance with its regular rates and terms which are 30 days from date of invoice. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection including but not limited to attorney fees, court costs and filing fees.

I authorize direct payment to GEC of any insurance benefits. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

If you do not have insurance, payment is due at the time of services are rendered unless payment arrangements have been approved in advance. To assist you we accept checks, MasterCard, Visa, Discover, American Express and Care Credit.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

SIGNED: _____ DATE: _____

WITNESS: _____

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the costs (like the copayment, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an out-of-network provider or facility and show the amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services towards your deductible and out-of-network limit.

If you believe you've been wrongly billed, you may contact No Surprises Help Desk at 1-800-985-3059.
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Prior to your procedure, you will be asked to sign a consent form such as the one below or one similar to it. Please read this, and if you have any questions, ask your physician prior to undergoing your procedure.

DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedure.

I (we) voluntarily request

□ **Brian McMorrow, MD** □ **Richard Riegel, MD** □ **Andrew Su, MD**
□ **Jeffrey Mathews, MD** □ **Rajeev Ramgopal, MD** □ **Jonathan Seccombe, MD** □ **Fred Williams, MD**

as my physician, and such associates, technical assistants, and other health care providers as he/she may deem necessary.

I (we) understand that the following surgical, medical, and/or diagnostic procedure(s) planned for me and I (we) voluntarily consent and authorize these procedures:

□ Esophagogastroduodenoscopy with possible biopsy and/or polypectomy and/or dilation
□ Colonoscopy with possible biopsy and/or polypectomy and/or dilation
□ Flexible Sigmoidoscopy with possible biopsy and/or polypectomy and/or dilation
□ Other: _____

I (we) understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I (we) authorize my physician, and such associated, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty, guarantee or assurance has been made to me as to the results of the procedure and that it may not cure my condition. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks, and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots, in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: drug reaction, bleeding, perforation, missed pathology, infection, cautery burn, cardiac arrhythmia, and aspiration.

I (we) understand that anesthesia involves additional risks and hazards, but I (we) request the use of anesthesia for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetics including respiratory problems, drug reactions, paralysis, brain damage and even death.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedure to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

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