



## GATEWAY GASTROENTEROLOGY INC.

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

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Jeffrey Mathews, M.D.  
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Cheri Carmody, A.N.P.  
Kaitlin Schild, A.G.N.P.  
Danielle Smith, F.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 listed below. Please note, this is **NOT** our office location.

St. Luke's Hospital  
232 S. Woods Mill Road  
East Medical Building, Suite 130  
Chesterfield, MO 63017

Please arrive 1 hour prior to your appointment time.

From Hwy 40/Interstate 64:

- Go north on Woods Mills Road (Hwy 141) ½ mile to Conway Road.
- Turn right at the stoplight onto Conway Road. Turn left into the hospital east entrance.
- Turn left again into the east surface parking lot or East Garage (3 levels). There is direct access to the East Medical Building from Level 1 or 3. Complimentary valet parking is available and is highly encouraged. Valet parking begins at 7:30am.

If you cannot keep your scheduled appointment, please notify us at least **2 business days** before your scheduled time. Please see additional information included in this packet regarding our cancellation policy

**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:**

- Golytely – Prescription requires and provided. **Please take this script to your pharmacy at least 2 weeks prior to your scheduled appointment as to not cause any delays in getting your script.**
- Four 5mg. Dulcolax laxative formula pills.

**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 a clear/transparent liquid diet. Examples: Water, Soda (any kind), Gatorade, black coffee, tea, popsicles, Jell-O, broth/bouillon, apple juice, white grape juice, white cranberry juice.
- **AVOID Red or Purple Liquids.**
- Drink plenty of clear liquids throughout the day to stay hydrated.
- **NOTHING AFTER MIDNIGHT EXCEPT FOR THE PREP AS DIRECTED.**
- **NO ALCOHOL.**
- **The MORNING OF YOUR PREP:** Add water to the fill line of Golytely container and put in the refrigerator to chill.

Procedure Time 6:20am to 10:20am Start PART A at 2PM the afternoon before your procedure, finish by 4pm.

1. Take four 5 mg. Dulcolax laxative formula pills.
2. Drink four 16 oz cups of Golytely (64 oz. total); drink one cup every 20 minutes until done with all four cups.

**You can continue to drink clear liquids**

Start PART B at 10pm the evening before your procedure, finish by Midnight

1. Drink four 16 oz cups of Golytely (64 oz. total); drink one cup every 20 minutes until done with all four cups.

**\*\*\* AFTER FINISHING PREP PART B – DO NOT EAT OR DRINK ANYTHING ELSE.\*\*\***

Procedure Time 11:00am to 2:20pm Start PART A at 5PM the afternoon before your procedure, finish by 7PM.

1. Take four 5 mg. Dulcolax formula pills.
2. Drink four 16 oz cups of Golytely (64 oz. total); drink one cup every 20 minutes until done with all four cups.

**You can continue to drink clear liquids**

Start PART B at 5AM the morning of your procedure, finish by 7AM

1. Drink four 16 oz cups of Golytely (64 oz. total); drink one cup every 20 minutes until done with all four cups.

**\*\*\* AFTER FINISHING PREP PART B – DO NOT EAT OR DRINK ANYTHING ELSE.\*\*\***

- 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:**

- You may take your usual medications with sips of water as early as possible the day of the procedure.
- Arrive at St. Luke's GI/Endoscopy Lab 1 hour prior to your scheduled procedure time.
- **SOMEONE WILL NEED TO DRIVE YOU TO AND FROM THE HOSPITAL.**
  - You and your driver can plan to be at the hospital approximately 2 hours total. The hospital **WILL NOT** allow transportation by Taxi, Uber or Lyft.
  - 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 included in this packet. These forms are required for Gateway Gastroenterology.

## **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 antiplatelet medication with aspirin, please contact our office at 314-529-4900 to discuss.

**Please call our at least 2 weeks prior to your procedure to speak with our nursing staff if you are taking any of the following medications. We will discuss with you about safely stopping any of these medications prior to your procedure**

**Coumadin, Jantoven (warfarin)**

**Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban), Bevyxxa (betrixaban)**

**Clopidogrel (Plavix), Prasugrel (Effient), Ticagrelor (Brilinta), Pletal (cilostazol)**

**Iron:** If you are having a colonoscopy, please stop the iron four (4) days before the procedure. Iron can interfere with the preparation resulting in a poorly cleaned colon. You do not need to stop iron if you are only undergoing upper endoscopy.

**Antibiotics for procedures:** According to the latest guidelines from the American Heart Association and the American Society for Gastrointestinal Endoscopy, antibiotics are NOT required for any routine upper endoscopy or colonoscopy. If your physician insists on you being on an antibiotic, please ask them to prescribe and instruct you on how and when to take the antibiotic.

**Insulin:** Please contact your prescribing physician and inform him/her that you cannot eat or drink after midnight before your procedure, then ask for instructions on how to adjust your insulin dosages.

**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 or after 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](http://www.gatewaygi.com)) for more detailed information regarding the physician you will be seeing, and other services offered. You may also check our FAQ's for commonly asked questions that you may have about your upcoming procedure.**

## 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.

## Gateway Gastroenterology “No Show” Procedure Appointment Policy

At Gateway Gastroenterology, procedure appointments are scheduled so that there is adequate time to prepare you for the procedure and for the procedure itself. We urge you to keep your appointment and arrive **ONE HOUR** before your scheduled time. As a courtesy, text messages and or email will be sent in advance to remind you. If you cannot keep your appointment, please notify us at least 48 hours in advance. This will help us open up the time for others waiting to be seen. If you are having difficulty tolerating the colonic cleanse the night before your procedure, please contact our on-call physician through our after-hours exchange. **If you do not notify us of your cancellation at least 48 hours in advance, you may be assessed a \$100.00 “no-show” service charge.** This charge is NOT reimbursable by your health insurance company, you will be billed directly. Future scheduling will be contingent upon this charge being paid in full. Thank you for your cooperation.

## 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.

**Attention: St. Luke’s employees - UMR does not cover screening colonoscopy under the age of 45.**

### **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.

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Patient Signature

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Date



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Danielle Smith, F.N.P.

### Welcome

Dear Patient:

Welcome to Gateway Gastroenterology! We look forward to meeting you. We'd like to take this opportunity to tell you a little about our practice.

Gateway Gastroenterology is a group of seven 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 including screening colonoscopy, upper endoscopy, testing for dietary intolerance, etc.

Our goal is to provide outstanding care in a timely, courteous, and professional manner. All of our physicians are committed to ongoing education and will make every effort to provide you with the most up to date and thorough care possible.

We will try hard to make your experience with us as hassle-free as possible. To this end, we will see you in a timely manner, return phone calls, and communicate with your other physicians.

Our practice includes Board Certified Nurse Practitioners who are specialized in gastroenterology and assist us in seeing patients in the office. Through their work, we are able to provide greater office time availability and flexibility. Our staff consists of friendly and knowledgeable people that are available to help with your scheduling, billing, and insurance needs.

We look forward to working with you.

Respectfully,

Jonathan C. Seccombe, M.D.

Jeffrey E. Mathews, M.D.

Jason M. Haas, D.O.

Brian C. McMorrow, M.D.

Fred H. Williams, M.D.

Rajeev Ramgopal, M.D.

Richard T. Riegel, M.D.

Cheri M. Carmody, A.N.P.

Kaitlin C. Schild, A.G.N.P.

Amelia L. Aubuchon, F.N.P.

Danielle M. Smith, F.N.P.

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



For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below. Thank You!

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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Medication Allergies and Reactions**

☐ (check if No Known Drug Allergies)

**Medication Name**  
(Prescription Medications)

**Dosage**

**Frequency**  
(how often)

**Reason for Use**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

List name(s) of any Over the Counter Medications/Herbal Supplements

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Pharmacy Name:**

Local \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mail Order \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Financial Disclosure

Dear Patient:

We would like to take this opportunity to welcome you, and to let you know that we are committed to providing you with the best possible care. Please take a few minutes to read this important information regarding our financial policies. We will gladly discuss your proposed treatment and answer any questions you have related to your charges:

For billing purposes, there are separate service components for which you will be billed separately:

1. **Physician Professional Charge:** We will bill this charge for you. This billing is for the physician's professional services that are provided during your procedure.
2. **Facility Charge:** There will also be a facility bill for the use of the facility in which your procedure is being performed. If the procedure requires additional services, the billing will be increased depending on the added requirement. The facility will bill these charges separately to you.
3. **Laboratory and Pathology Charge:** If you have a biopsy taken or polyp(s) removed, you will receive a bill from the laboratory that processes your pathology.
4. **Anesthesia Charge:** If your procedure utilizes the services of the anesthesia provider, this professional charge will be billed separately to you. The billing is for anesthesia provider's professional services that are provided during your procedure.

**Payments made to the facility on the day of the service are credited towards the facility charge only.**

If you have insurance, we will file a claim for you. Please understand that your insurance is a contract between you and your insurance company and that complete payment to us is ultimately your responsibility. Under certain circumstances some insurance carriers may not always cover or may deny payment for services provided. Our office will bill your insurance first. After your insurance processes the claim, we will forward a statement to you if there is any patient responsibility. Please remit payment in a timely fashion or call the office to make payment arrangements.

If you belong to an insurance plan, we will follow guidelines set forth in those plans. Please be sure to contact your primary care physician **if** your insurance requires a referral. Services cannot be rendered if proper authorization has not been given. We **DO** participate in Medicare.

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

We recognize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. We are willing to work with you, but we need you to communicate with us. We do use outside agencies as a means of collections should we deem it necessary.

If you have any questions about the above information or any uncertainty regarding insurance coverage, don't hesitate to ask us. We are here to help you. You can reach our office at 314-529-4900.

# 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 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 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 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.

**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

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 McMorro**, MD      ☐ **Richard Riegel**, MD      ☐ **Jason Haas**, DO  
☐ **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.