GATEWAY GASTROENTEROLOGY INC.

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

Jason Haas, D.O.
Jeffrey Mathews, M.D.
Brian McMorrow, M.D.
Rajeev Ramgopal, M.D.
Richard Riegel, M.D.
Jonathan Seccombe, M.D.
Fred Williams, M.D.
Amelia Aubuchon, F.N.P.
Cheri Carmody, A.N.P.
Kaitlin Schild, A.G.N.P.
Danielle Smith, F.N.P.

Flexible Sigmoidoscopy 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 procedure. 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 Mill 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 INSTRUCTIONS" SECTION ON THIS DOCUMENT CAREFULLY TO SEE IF YOU REQUIRE SPECIAL INSTRUCTIONS OR MODIFICATIONS.

Needed from Pharmacy for Preparation:
Please get these items ahead of time.

- One bottle of Magnesium Citrate (10 ounces)
- Two 5mg. Dulcolax laxative formula pills.
- One Fleets enema (DO NOT use mineral oil based enema)

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/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.**
- Prior to your evening liquid meal, take one bottle of Magnesium Citrate.
- With that evening meal, take 2 Dulcolax pills.
- You may take your usual medications as prescribed by your physician.
- **DO NOT CONSUME ANYTHING AFTER MIDNIGHT EXCEPT MEDICATIONS.**

The day of your 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.
- Approximately one-half hour before you leave to come in for your flexible sigmoidoscopy, please give yourself one fleets enema. Attempt to hold this in as long as possible.
- Arrive at St. Luke's GI/Endoscopy Lab 1 hour prior to your scheduled procedure time.
- **PLEASE BRING A DRIVER WITH YOU BECAUSE IF YOU ELECT TO HAVE YOUR PROCEDURE WITH ANESTHESIA, YOU WILL NOT BE ABLE TO DRIVE HOME.**
    - 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 had anesthesia during your procedure.
- 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 us at least 2 weeks prior to your procedure to speak with our nursing staff if you are taking any of the following blood thinners. 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)

If you are currently taking any weight loss medications like:
Lomaira (phentermine hydrochloride): available as a tablet
Ionamin (phentermine resin): available as a capsule
Suprenza (phentermine hydrochloride): available as 7 orally disintegrating tablets
Qsymia (phentermine hydrochloride and topiramate): available as a capsule
Adipex-P (phentermine hydrochloride): available in capsule and tablet form
PLEASE STOP taking any of these for 7 days prior to your procedure

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) 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.

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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.

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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 biopsy.

4. **Anesthesia Charge:** If your procedure utilizes the services of the anesthesia provider, this professional charge will be billed separately to you. This billing is for the 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 McMorrow, 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.