Valley Gastroenterology

12401 E Sinto Ave.
Spokane Valley, WA 99216
P: 509-922-2055 / F: 509-922-2307

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Esophagogastroduodenoscopy (EGD)

You have been scheduled with _____ for _____ on _____ check in time _____.

Please read through the entire preparation packet so that you are well prepared for your appointment and are familiar with our office policies.

This packet includes:

- Preparation Instructions
- Fiber free breakfast and Clear liquid handout
- Cancellation policy
- Description of the procedure
- Sample of a consent form
- HIPPA form
- Patient Rights

Please remember to fill out and mail in the Patient Forms listed below.

- Patient Information
- Past Health History Questionnaire

  ***You may choose to log in to our Patient Portal to fill out forms.**

Please do not hesitate to contact our office at (509) 922-2055 with any questions that may arise.

5 Days Prior	3 Days Prior	2 Days Prior	1 Day Prior	Procedure Day
Carefully review the upcoming prep instructions. If you have difficulty swallowing or with food not moving through swallowing tube, stop the following  **Stop** Iron supplements, Fish oil, Garlic tabs, Vitamin E, Ginko, Turmeric. **Stop** Blood Thinners such: Prasugrel (Effient), Cilostazol (Pletal), Plavix (clodpidogrel), Tecagrelor (Brilinta), Aggrenox, Ticlid, Coumadin (Warfarin). **Stop** NSAIDs for complete list please visit our website http://valley-gi.com Patient Education. You may take Tylenol.	If you have difficulty swallowing or with food not moving through swallowing tube, stop the following  **Arrange a ride.** You will be sedated for your exam and must have a driver to take you home or the exam will be cancelled. **Taxi or public transportation is not acceptable.** On your procedure day, you will not be able to work, sign important papers, drive, operate equipment, drink alcohol or take sedatives for the remainder of that day.	If you have difficulty swallowing or with food not moving through swallowing tube, stop the following  **Stop** Blood thinners such as: Pradaxa, Xarelto, Eliquis, Savaysa, Lixiana Drink eight glasses of clear liquids throughout the day to stay hydrated. _____ **Appointments that are not cancelled or rescheduled 2 business days in advance will be subject to an administrative fee of $100.00.**	**NO SOLID FOODS AFTER 8 PM** Only a small amount of clear liquids up to 3 hours prior procedure	Take your regularly scheduled heart, blood pressure or seizure medications. **Do not** take your diabetic medication. If you use Asthma Inhalers, please bring them with you. Nothing by mouth **3 hours** prior to your procedure time. Your **DRIVER** will need to sign you out of the facility and must be available in our waiting area during procedure. You may want to bring a book or a tablet while you are waiting for the procedure to start.

INFORMED CONSENT FOR GASTROINTESTINAL PROCEDURES

Explanation of procedure:

Your physician has advised a thorough endoscopy exam of your digestive tract lining to better assess your problem. Prior to your procedure you may receive conscious sedation with a sedative, Versed, and a pain suppressant, Fentanyl. Together, these medicines may affect your memory, coordination, and judgment. During endoscopy, pictures may be taken. The physician may take samples of tissue to send to a lab for diagnosis. After the procedure, the doctor will speak with you about preliminary results and treatment.

PRINCIPAL RISKS AND POSSIBLE COMPLICATIONS

YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT THE PROCEDURE. The following risks infrequently occur during Gastrointestinal Endoscopy:

1. **Cardiopulmonary**: The major adverse effect of sedative medication is respiratory depression and serious cardiorespiratory events. You will be closely monitored throughout the procedure.
2. **Perforation**: Injury to the gastrointestinal tract with possible leakage of gastrointestinal contents into the body cavity may occur. If this occurs, surgery to close the leak and/or drain the area may be required.
3. **Bleeding**: Bleeding, if it occurs, is usually a complication of biopsy, polypectomy, or dilation. Management of this complication may consist of careful observation, transfusion, or a surgical operation.
4. **Other risks**: Despite careful examination, Cancer and other significant lesions can be missed. Drug reaction and complications from other diseases that you may already have may occur. Deaths are extremely rare, but remain a remote possibility. For EGD teeth can be potentially loosened or chipped.

I hereby authorize and permit Pradeep Atla or Ajay Pabby, M.D. and whomever they may designate as their assistant to perform upon me the following procedure(s)

- **EGD (esophagogastroduodenoscopy):** Examination of the esophagus, stomach, duodenum. If active bleeding is found, coagulation by heat may be performed or injection of a chemical to stop the bleeding may be given. If polyps or foreign body are found, they may be removed. If narrowed areas are found, they may be dilated with or without X-ray assistance.
- **Colonoscopy:** Examination of all or portion of the colon. Older patients and those with extensive diverticulosis or previous pelvic surgery are more prone to complications. Polypectomy (the removal of small growths called polyps) is performed, if necessary, by the use of a wire loop, forceps or electrical current.

I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed to the risks and possible complications of my procedure. I have been informed not to drive, operate machinery, consume alcohol, make critical decisions or sign legal documents until tomorrow. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If any unforeseen condition arises during this procedure calling for, in the physician judgment, additional procedures, treatments, or operations, I authorize him to do whatever he deems advisable.

Signature: **SAMPLE** **Date**: _____ **Time**: _____
(Patient or person legally authorized to consent for the patient)

CONSENT FOR RELEASE OF INFORMATION AND FACILITY OWNERSHIP INTEREST

I consent to the taking and publication of any photographs made during my procedure for use in the advancement of medical education. I hereby authorize the center to disclose all or part of my medical records to any person or corporation, which is, or may be liable for all or part of the facility charges. A copy of my medical records will be sent to my primary care physician and/or referring physician, unless otherwise noted. I hereby acknowledge I am aware that my treating physician has ownership interest in this Surgical Facility, and that I elect to use this Facility.

Signature: **SAMPLE** **Date**: _____ **Time**: _____
(Patient or person legally authorized to consent for the patient)

Relationship to patient: _____ **Witness:** _____

Valley Endoscopy Center
12401 E Sinto Ave, Spokane WA 99216

Patient name:
DOB:

CANCELLATION POLICY

To Our Patients:

We have experienced a significant increase in the demand for medical procedures and services. We have also seen increased costs associated with these services. We are committed to providing you with the best possible care and plan for each patient's time in our office.

Unfortunately, we have also seen an increase in the number of patients failing to come to their appointments or cancelling late. This prevents us from having the ability to fill that appointment and meet other patient's medical needs.

We will charge the following fees for cancellations:

$100.00 for medical procedures

$50.00 for consults

$25.00 for follow up appointments

To avoid assessment of these fees, you must give our office a forty-eight-hour notice of cancellation (2 business days) prior to the scheduled appointment. Cancellation of follow up appointments requires a 24-hour notice (1 business day).

Insurance companies will not cover this fee!

We appreciate your understanding of this policy and thank you for your cooperation!

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

The patient has the right to:

Respectful care given by competent personnel with consideration of his/her privacy concerning his/her medical care.

Know that the physicians (Paul Craig, M.D. and Clinton Poppel, M.D.) are owners and have a financial interest in Valley Endoscopy Center.

Be given the name of his/her attending physician, the names of all other physicians directly assisting in his/her care, and the names and functions of other health care persons having direct contact with the patient.

Have records pertaining to his/her medical care treated as confidential.

Know what Endoscopy Center rules and regulations apply to his/her conduct as a patient.

Expect emergency procedures to be implemented without unnecessary delay. In the event the need to transfer the patient to another facility is necessary, the responsible person and the facility that the patient is transferred to will be notified prior to transfer.

Good quality care and high professional standards that are continually maintained and reviewed.

Full information in layman's terms concerning diagnosis and treatment. If it is not medically advisable to give this information to the patient, the information shall be given to the responsible person on his/her behalf.

Information on after-hour emergency care.

Receive from his/her physician the information necessary to give informed consent prior to the start of any procedure or treatment.

Be advised of participation in a medical care research program or donor program. The patient shall give consent prior to participation in such a program. The patient may also refuse to continue in a program in which he/she has previously given informed consent to participate.

Refuse drugs or procedures and have a physician explain the medical consequences of the patient's refusal of drugs or procedures.

Be given medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.

Be free from all forms of harassment, abuse and/or neglect.

Exercise his/her rights without fear of discrimination or reprisal.

Have access to an interpreter with adequate notice given by the patient prior to appointment.

Be provided with, upon written authorization, access to all information contained in his/her medical record.

Be provided accurate information regarding the competence and capabilities of the Endoscopy Center.

Receive information regarding methods for expressing suggestions or grievances to the Endoscopy Center.

Receive information regarding fees for services and payment policies.

Have an appointed surrogate decision-maker if he/she is legally incompetent.

<u>The patient has the responsibility to:</u>

Follow instructions given by his/her surgeon, anesthesiologist and nurse regarding pre-operative and postoperative care.

Provide the Endoscopy Center staff with all medical information which may have a direct effect on the care provided at the Endoscopy Center.

Provide the Endoscopy Center with all information regarding third party insurance coverage, fulfill financial responsibility for all services received as determined by the patient's insurance carrier and the Endoscopy Center.

ADVANCED DIRECTIVE INFORMATION

An Advanced Directive is a written instruction, such as a Living Will or Durable Power of Attorney for Health Care, recognized under state law relating to the provision of health care when the individual who has issued the directive is incapacitated. If you would like Valley Gastroenterology, P.S. and Valley Endoscopy Center to have a copy of your advanced directive, please bring a copy with you for your file. If you would like information regarding advanced directives, we will provide Advanced Directive and Durable Power of Attorney for Health Care forms.

Valley Endoscopy Center's policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, it is the Governing Board's decision that if an adverse event occurs during treatment at the facility and a patient's medical condition deteriorates, resuscitative or other stabilizing measures will be initiated and the patient will be transferred to an acute care hospital. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with Advance Directives or health care Power of Attorney. The patient's agreement with this policy will not revoke or invalidate any current health care directive or power of attorney.

GRIEVANCE POLICY

Valley Endoscopy Center supports our patient's rights by providing a grievance process to respond to your concerns regarding patient rights and quality of care.

Grievances or complaints will be treated without fear of reprisal.

Please include in your written response the name(s) of the persons involved with your care, the description of the grievance and the proposed outcome of the grievance. Please be as specific as possible with your concerns so that we can address them in a timely manner.

The Practice Administrator will review your grievance and follow up with you in writing within 7 days, including how the grievance was investigated and the outcome of the investigation.

You can contact us verbally or in writing by:

Verbal Complaint – Ask to speak to the Practice Administrator at (509) 922-2055.

Written Grievance - Valley Endoscopy Center
Attn: Practice Administrator
Personal and Confidential
12401 E. Sinto Ave.
Spokane Valley, WA 99216

You may also contact:

Office of the Medicare Beneficiary Ombudsman:
www.cms.gov/center/ombudsman.asp
Medicare Help and Support: 1-800-MEDICARE
or
Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
Fax: 360-236-2626

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