

CAROLINA DIGESTIVE ENDOSCOPY CENTER
300 Billingsley Road, Suite 200-B
Charlotte, NC 28211
Phone: (704) 927-6066

Patient Procedure Instructions

Patient Name: _____ DOB: _____ Chart # _____

Date of Procedure: _____ Arrival Time: _____

Please read and initial the following important policies

_____ Please complete the paperwork in your packet and bring it with you on the day of your procedure. Please bring identification with your picture on it and your Insurance Card.

_____ A responsible driver **MUST** accompany you to the Endoscopy Center and must stay at the facility for the duration of your procedure and take you home when you are discharged. **Your procedure will be cancelled if you arrive alone or if the person bringing you cannot stay at the facility for the duration of your procedure.** Plan on being at the center approximately 2-2 ½ hours.

_____ If you asked for an interpreter. The interpreter will meet you at the Endoscopy Center the day of your procedure. There is no additional charge for the interpreter. If you asked for an interpreter and changed your mind please call the **Endoscopy Center 704-927-6066.**

_____ Please make sure that you have received a copy of your preparation (prep) instructions. If you do not completely understand the prep instructions, please call **Colon Prep Center at 800-349-0285.** If you receive prep instruction in the office, please call and speak to the physician scheduler for clarification.

_____ If you need to cancel your procedure, you must call our office three (3) business days prior to the procedure. If unforeseen circumstances arise the morning of the procedure, you must call the endoscopy center 704-927-6066. The center opens between 5:30am and 6:00am. **If you do not show up for your procedure and you have not called our office or the endoscopy center you will be charged a \$100.00 No Show fee.**

_____ Our Center's policy on **Advance Directives (Living Will)** is: "The Center's policy for limiting advance directives is to always attempt to resuscitate a patient and transfer the patient to the hospital in the event of deterioration." Please see our website for applicable State Laws on Advance Directives.

_____ **Please contact your insurance carrier prior to the procedure. It is your responsibility to verify your benefits and obtain any necessary PCP referral. Our office will check to see if authorization is required.**

_____ **Any co pay and/or outstanding deductible up to \$500.00 will be collected at the time of your procedure. Patients without insurance coverage will be required to pay \$500.00 at the time of scheduling.**

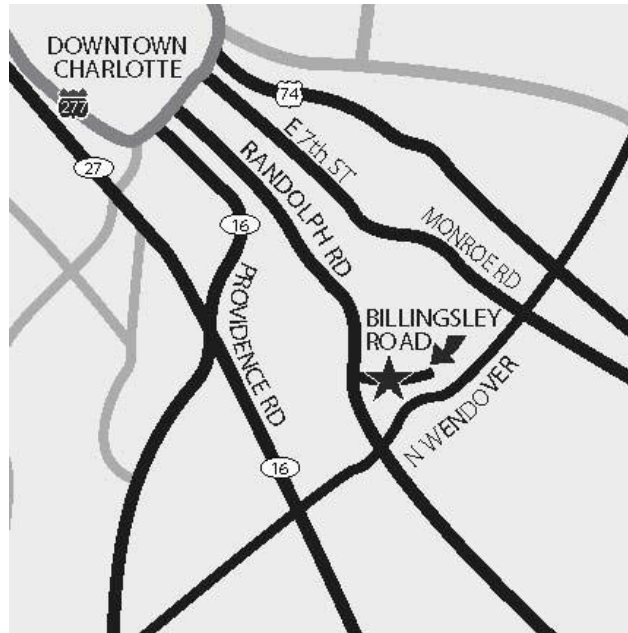
_____ Please do not wear jewelry to the center and please leave all valuables at home. Please do not apply any lotion, skin softeners or perfume, as this interferes with our monitoring equipment. Please dress comfortably and wear comfortable, flat-soled shoes (**AVOID wearing high heeled shoes**).

I have read and understand the policies above.

Patient's Signature

Date

Charlotte



Charlotte Endo Center Map & Driving Directions

From the North:

Head South on I-77
Take exit 11 for I-277 S / Brookshire Frwy E
Merge onto W Brookshire Frwy / I-277
Take exit 2B on the left for US-74E / Independence Blvd
Merge onto US-74 E
Take exit 245A for Wendover Rd
Turn right at Randolph Rd
Turn right at Billingsley Rd

From the South:

North on Providence Rd
Turn right at S Wendover Rd
Turn left at Randolph Rd
Turn right at Billingsley Rd

From the West:

Head South on Billy Graham Pkwy toward W Woodlawn Rd
Continue on W Woodlawn Rd
Continue on Runnymede
Turn left at Sharon Rd
Turn right at S Wendover Rd
Turn left at Randolph Rd
Turn right at Billingsley Rd

From the East:

Take US-74 W / E Independence Blvd
Take exit 245 A / N Wendover Rd
Continue on N Wendover Rd
Turn right at Randolph Rd
Turn right at Billingsley Rd

**CAROLINA DIGESTIVE ENDOSCOPY CENTER
PATIENT RIGHTS**

Patient will be accorded impartial access to available medical treatments regardless of race, creed, national origin, religion, sex, age, or handicap.

Patient is entitled to information regarding his/her rights at the earliest possible time in course of treatment.

Patient will have access to an interpreter when necessary and at earliest possible time.

Patient has the right to quality care by competent individuals adhering to high professional standards.

Patient has the right to inquire and be informed of providers' qualifications and credentialing criteria.

Patient has the right to change their provider if other qualified providers are available.

Patient will receive respectful care that at all times is considerate of his/her personal dignity.

Patient is entitled to personal privacy in treatment and in caring for personal needs.

Patient has the right to be free from harassment, neglect and abuse from staff, other patients and visitors.

Patient is entitled to confidential treatment of his/her medical records and must consent to their release except when required by law.

Patient is entitled to care that avoids unnecessary discomfort and pain.

Patient has right to be free from seclusion and restraints in accordance with Center policies.

Patient is entitled to be involved in his/her discharge planning and to receive information concerning his/her continuing healthcare needs and the means for meeting them, as well as the alternatives.

Patient is entitled to refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal, including the right to refuse to participate in experimental research.

Patient has the right to expect reasonable continuity of care when appropriate and to be informed of available options when care is no longer appropriate or when transfer to another facility is necessary.

Patient is entitled to have emergency procedures implemented without delay.

Patient and/or authorized representative has the right to participate in decisions involving his/her health care, including diagnosis, evaluation, treatment and prognosis.

Patient shall not be subjected to non-emergency treatment, procedure, research or other programs without his/her voluntary and competent consent or the consent of legally authorized representative.

Patient is entitled to receive information about Center rules and regulations affecting patient care and conduct including procedure for handling of patient complaints.

Patient is entitled to receive an itemized and detailed explanation of bill for services provided.

Patient has the right to access protective services and patient's legally authorized representative may exercise rights on behalf of patient.

**CAROLINA DIGESTIVE ENDOSCOPY CENTER
ADVANCE DIRECTIVES POLICY**

The Center's policy for limiting advance directives is to always attempt to resuscitate a patient and transfer the patient to the hospital in the event of deterioration.

(Patient's Signature)

(Date)

**CAROLINA DIGESTIVE ENDOSCOPY CENTER
PATIENT RESPONSIBILITIES**

Patient is responsible for providing accurate and complete information about his/her health including current complaints, past illnesses, hospitalizations, past and current medications including over the counter products and dietary supplements, any allergies and sensitivities and any other relevant information.

Patient is responsible for providing a responsible party to remain at the Center during his/her stay and to transport him/her home from the facility.

Patient and his/her representatives are responsible for reporting obvious risks regarding his/her care and any changes in patient's condition.

Patient, or patient representative, is responsible for expressing patient wishes and needs so appropriate care can be provided.

Patient is responsible for asking questions when they do not understand what they have been told about their care and what is expected of him/her.

Patient is responsible for clearly stating his/her concerns, worries and fears regarding handling of their follow-up care and treatment.

Patient and family are responsible for following the treatment plan as prescribed by the provider and participating in his/her care.

Patient and family are responsible for the outcomes of not following care and treatment plan.

Patient and family are expected to be considerate to the Centers' personnel and property.

Patient and family are expected to be kind to other patients and their families.

Patient and family are expected to follow the Centers' rules and regulations regarding patient care and conduct.

Patient and family are expected to behave in an appropriate manner at all times.

Patient and family are responsible for behavior that may place the health and well being of others at risk.

Patient is responsible for providing the Center's administration staff with accurate and timely information about his/her ability to pay for services.

Patient is responsible for promptly paying for services, including charges not covered by his/her insurance.

Patient is responsible for providing information about any living will, medical power of attorney or other directive that could affect his/her care.

If you have a question about your care or the safety of your surroundings, please let us know. If at any time you have a complaint or concern, you may contact your nurse, the charge nurse or **the Director**. You can expect the Endoscopy Center to respond in a timely manner. Although it is our desire to resolve your concerns at the local level, it is your right to make a complaint directly to the Accreditation Association for Ambulatory Health Care (AAAHC) or the NC Department of Health and Human Services (State Survey Agency) as follows:

Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section
2712 Mail Service Center, Raleigh, NC 27699-2712
1-800-624-3004 (Toll-free)
State Representative-Rita Horton
Web site: www.facility-services.state.nc.us
Visit the Ombudsmans's webpage at:
www.cms.hhs.gov/center/ombudsman.asp

AAAHC

5250 Old Orchard Road
Suite 200
Skokie, Ill. 60077
847-853-6060
www.aaahc.org

(Patient's Signature)

(Date)

Carolina Digestive Endoscopy Center

Patient Financial Responsibility Agreement

In order for Carolina Digestive Endoscopy Center to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENTS' RESPONSIBILITY.

As a patient of Carolina Digestive Endoscopy Center, you are hereby agreeing:

- To pay all non-insured charges, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised.
- To provide us with a copy of your current insurance card or other Proof of insurance at the time of EACH service, including hospital-based services. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.
- To obtain any required authorization under your insurance plan for our services from your primary care physician and/or your insurer prior to each appointment. If you do not receive the required authorization, your insurer may not pay us for our services. In these cases, you agree to personally pay any resulting unpaid charges.
- *****To monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding non-payment and to cooperate with CDHA to resolve the unpaid status of your account.**
- We charge a fee of \$100.00 to patients that do not arrive for their appointment or do not provide adequate notice.

Further, you agree that your physician and Carolina Digestive Endoscopy Center has the right to be paid for their services and you acknowledge:

- **That unpaid bills older than 60 days from date of service may be turned over to a debt collection agency or attorney for collection.**
- **That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.**

By my signature, I am indicating that I have read, understand and agree to the above provisions.

Patient or Guarantor Signature

Date

No form may be altered without express permission.

Carolina Digestive Endoscopy Center

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

Other: _____

Prepared By _____

Signature _____

Date _____

CAROLINA DIGESTIVE ENDOSCOPY CENTER

Per Statute 90-701, Carolina Digestive Health Associates, P.A. (CDHA) is required to disclose charges for anatomic pathology services provided us by AP Laboratories. AP Laboratories, LLC of Charleston, South Carolina will provide certain anatomic pathology services for our non-Medicare, non-Medicaid patients. Charges for these services will be included in your claim, which we will submit to your insurance company which may or not be covered.

AP Laboratories is charging the following fees to CDHA: \$30 for CPT Codes 88305 and 88312; \$20 for CPT Code 88313 and \$25 for CPT Code 88342.

Thomas Carico, MD is the Laboratory Director for AP Laboratories, LLC, at 2090 Executive Hall Road, Suite 165, Charleston, S.C. 29407. Phone number:- 843-300-3001.

Patient (or Patient's Representative) Signature

Date

2/6/2013

Checking Your Healthcare Insurance Benefits

After scheduling any procedure, we recommend you call your insurance carrier to verify your benefits. **It is your responsibility to determine what your benefits cover.** Please know that Carolina Digestive Health will provide your insurance carrier with all necessary information for your policy to cover the procedure at the maximum allowed amount.

Procedure

CPT Codes

Colonoscopy (outpatient)	45378-45386 – with and without findings
Colonoscopy (in office BCBS of NC @ Billingsley)	45378-45386 – with and without findings
EGD (outpatient)	43235-43259
EGD (in office BCBS of NC @ Billingsley)	43235-43259
Flex Sig (outpatient)	45330-45345
Flex Sig (in office BCBS of NC @ Billingsley)	45330-45345

Hospital Procedure (outpatient)

- Screening Colonoscopy: Preventative/Wellness (absence of symptoms and/or history)
- Diagnostic Colonoscopy: Symptoms and/or History exist requiring the procedure

If your doctor finds a polyp or other findings during the procedure, your insurance carrier may no longer consider this a preventative/wellness screening procedure. It may then be considered a diagnostic procedure and your insurance benefits may change. Please verify your benefit for both when calling your insurance company.

You will incur up to 4 separate statements for your procedure: (1) the physician’s charge (2) the facility charge from the ambulatory surgery center (3) pathology (if any polyps/biopsies are removed) (4) anesthesia.

On the day of you procedure, you will be given anesthesia.

You will receive a phone call from CDHA regarding your benefits 1 week prior to your procedure, if you owe anything at the time of the procedure. If you do not receive a call you may contact the benefits department at 704-218-3169.

****Please keep in mind you will not receive a phone call if you do not owe anything at the time of the procedure.**

If you received a bill from one of the outside vendors below, please contact them directly regarding billing questions, as we are not the providers of those services.

Carolina Endoscopy Centers	Anesthesia	Pathology
Billingsley	Carolina Digestive 704-372-7974	Carolina Digestive 704-372-7974
Pineville	Carolina Anesthesia 800-951-7850	Carolina Pathology 704-973-5500
Monroe	Carolina Anesthesia 800-951-7850	Celigent Diagnostic 704-973-5500
University/Huntersville	American Anesthesiology 888-280-9533	Carolina Pathology 704-973-5500

Patient MRN: _____

Please initial the following line, stating we provided you with the above information: _____

Patient Name: _____

Patient MRN: _____

Patient DOB: _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature

Date

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____
Age: _____ Notes: _____

Sex

Male Female Other

Email

Please check one as your preferred email for communications

Personal: _____ Work: _____

Race

Select one or more

White Black or African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Unknown Patient declines to specify

Ethnicity

Hispanic or Latino Not Hispanic or Latino Patient declines to specify

Preferred Language

English Spanish; Castilian Vietnamese Patient declines to specify

Contact Preference

Letter Email Cell phone Telephone call - Home Patient declines to specify

Other: _____

Pharmacy

Name Address Phone

Past or Present Medical Conditions

None

<input type="radio"/> Arthritis	<input type="radio"/> Artificial Heart Valve	<input type="radio"/> Alzheimer's Disease	<input type="radio"/> Anemia	<input type="radio"/> Asthma / Bronchitis
<input type="radio"/> Bleeding problems	<input type="radio"/> Colon cancer	<input type="radio"/> COPD / Emphysema	<input type="radio"/> Crohn's Disease	<input type="radio"/> Depression
<input type="radio"/> Diabetes	<input type="radio"/> Fibrositis / Fibromyalgia	<input type="radio"/> Gallstones	<input type="radio"/> Glaucoma	<input type="radio"/> Heart disease
<input type="radio"/> Heart Murmurs	<input type="radio"/> Hepatitis A	<input type="radio"/> Hepatitis B	<input type="radio"/> Hepatitis C	<input type="radio"/> High blood pressure
<input type="radio"/> Colon polyp history	<input type="radio"/> HIV	<input type="radio"/> Irritable Bowel Syndrome	<input type="radio"/> Kidney disease	<input type="radio"/> Parkinson's Disease
<input type="radio"/> Reflux Disease (GERD)	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Seizures	<input type="radio"/> Ulcer Disease	<input type="radio"/> Stroke
<input type="radio"/> Thyroid disease	<input type="radio"/> Tuberculosis	<input type="radio"/> Ulcerative Colitis	<input type="radio"/> Defibrillator	<input type="radio"/> Other: _____

Other: _____ Other: _____

Previous Procedures

None

<input type="radio"/> Defibrillator Placement	<input type="radio"/> Pacemaker Insertion	<input type="radio"/> Other: _____
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When: _____ When: _____

Immunizations

None

<input type="radio"/> Influenza, seasonal, injectable	<input type="radio"/> Pneumonia vaccine	<input type="radio"/> Other: _____
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When: _____ When: _____

Diagnostic Studies/Tests

None

<input type="radio"/> Abdominal Ultrasound	<input type="radio"/> EGD	<input type="radio"/> Colonoscopy	<input type="radio"/> Flexible Sigmoidoscopy	<input type="radio"/> CT Abdomen
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When: _____ When: _____ When: _____ When: _____

<input type="radio"/> Mammography; bilateral	<input type="radio"/> Other: _____
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When: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Divorced	<input type="radio"/> Separated	<input type="radio"/> Widowed
<input type="radio"/> Civil Union	<input type="radio"/> Unknown	<input type="radio"/> Other		

Alcohol

None

<input type="radio"/> Type spirits	Quantity	Number	Frequency
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Caffeine None caffeine Intake: _____**Tobacco****Smoking Status** Current every day smoker Current some day smoker Former smoker Never smoker Smoker, current status unknown Light tobacco smoker Heavy tobacco smoker Unknown if ever smoked

Type

Started

Quit

Quantity

Frequency

Drug Use None Type
Marijuana Cocaine IV Drugs

Quantity

Number

Frequency

Family Medical History No knowledge of family history**No family history of** Celiac sprue Colon polyps Ulcerative Colitis / IBD Colon cancer Liver disease**Health Status**

Deceased/At Age

 _____ _____ _____ _____

Cause of Death

Diagnoses

History of colon cancer

History of colon polyps

Crohn's disease, colon

Diabetes mellitus (Type I)

Diabetes mellitus (Type II)

Gallstones

Pancreatitis

Ulcer, gastric

Ulcerative colitis

Other:

Other:

 Father
Mother
Brother
Sister

Review Of Systems

Allergic/Immunologic

None Y N
 HIV exposure
 persistent infections
 strong allergic reactions or urticaria

Cardiovascular

None Y N
 chest pain
 irregular heart beat
 Shortness of Breath
 Swelling of Ankles
 Pacemaker
 Defibrillator
 Stents

Constitutional

None Y N
 Feeling Tired
 fever
 sweats/chills
 weight gain
 weight loss
 Pregnant
 Jaundice

ENMT

None Y N
 difficulty swallowing
 nose bleeds
 sore throat
 Hearing Aid
 Hoarseness
 Sinus Problems

Endocrine

None Y N
 excessive thirst
 hair loss
 heat intolerance

Eyes

None Y N
 Blurred Vision
 Glaucoma
 Contacts or Glasses

Genitourinary

None Y N
 frequent urination
 Blood in Urine
 Incontinence

Gastrointestinal

None Y N
 abdominal pain
 abdominal swelling
 change in bowel habits
 constipation
 diarrhea
 heartburn
 nausea
 vomiting
 Anal Itching
 Anal Pain/Sore
 Appetite loss
 Belching
 Bloating
 Difficulty Swallowing
 Get full easily
 Incontinence of Stool
 Pain on Swallowing
 Pain when Defecating
 Black / Tarry Stool
 Maroon Stool
 Rectal Bleeding
 Vomiting Blood
 "Coffee Grounds"
 blood in stool

Hematologic/Lymphatic

None Y N
 Anemia
 easy bleeding/bruising
 past blood transfusion

Integumentary

None Y N
 itching
 skin ulcers
 rashes

Musculoskeletal

None Y N
 Back pain
 Joint pain
 Muscle Pain
 Joint Replacements
 Joint Swelling

Neurological

None Y N
 fainting
 frequent headaches
 seizures
 Brain/Spinal Injury
 Confused
 Weakness/Numbness

Psychiatric

None Y N
 anxiety
 depression

Respiratory

None Y N
 Chronic cough
 Sleep Apnea
 Use of C-PAP
 Difficulty opening Mouth
 Positive TB skin test
 wheezing
 DifficultyTurning head
 Use of Oxygen @ Home