CAROLINA ENDOSCOPY CENTER
1321 E. Sunset Drive
Monroe, NC 28112
Phone: (704) 261-1220

Patient Procedure Instructions

Patient Name: _____ Chart # _____

Date of Procedure: _____ Arrival Time: _____

Please read and initial the following important policies

_____ 1. Please complete the paperwork in your packet and bring it with you to the day of your procedure.

_____ 2. Please bring identification with your picture on it and your Insurance Card.

_____ 3. A responsible driver MUST accompany you to the Endoscopy Center and must stay at the facility for the duration of your procedure and return you to your 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.

_____ 4. If a need is identified, the scheduler will arrange for an interpreter to be present at the center for your procedure. This will be at no cost to the patient. If you decline the interpreter, please let the scheduler know.

_____ 5. 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 our office and speak to the scheduler for clarification.

_____ 6. 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 phone number listed above. 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.**

_____ 7. Our Center's policy on **Advanced Directives (Living Will)** is: "Regardless of Advanced Directives, a full resuscitation attempt will occur in the event it is needed." Please see our website for applicable State Laws on Advanced Directives.

_____ 8. The Patient's Rights and Responsibilities are provided to you in your packet. Please review these forms, sign, date and take to the Center on the day of your procedure.

_____ 9. Please do not wear jewelry to the center and please leave all valuables at home.

_____10.Please do not apply any lotion, skin softeners or perfume, as this interferes with our monitoring equipment.

I have read and understand the policies above.

_____

Patient's Signature Date

April 2012

CAROLINA ENDOSCOPY CENTERS
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 of 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 ENDOSCOPY CENTERS
ADVANCE DIRECTIVES POLICY

Regardless of advance directives, a full resuscitation attempt will occur in the event it is needed.

_____ _____
(**Patient's Signature**) (**Date**)

Revised August 2009; November 2010; July 2011

CAROLINA ENDOSCOPY CENTERS
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 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

_____ _____

(**Patient's Signature**) (**Date**)

Revised: August 2009; November 2010; July 2011

Carolina Endoscopy Center

ALTERNATIVE CONFIDENTIAL COMMUNICATIONS AND ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date of Birth _____

If we are unable to reach you, we will need an alternative method of communicating information to you. Check the box next to the method(s) you would like Carolina Endoscopy Centers to use to communicate personal health, treatment, or payment information to you. This is the most current request that supercedes all prior requests. You may update this request as needed.

☐ E-mail: I recognize that email may not be secure, but I authorize you to email me anyway**.**

_____
(E-mail address at which I wish to be contacted)

☐ I authorize you to leave detailed information at the following number

Phone _____

☐ Alternative Contact: _____
(name of person CEC may contact when unable to reach me)

I understand that this contact person is permitted to receive detailed health information, such as test results.

Phone: _____

Address: _____

By signing below I authorize Carolina Endoscopy Centers to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Carolina Endoscopy Centers describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time.

_____ _____
Signature Date

_____For Office Use Only_____

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

- ❑ An emergency existed and a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ Unable to communicate with the patient for the following reason:

_____

- ❑ Other:

_____

CEC Employee_____
Date_____

June 2008

Patient History Form

Name_____ **Date of Birth** _____ **Age** _____
Male □ Female □ **Height** _____ **Weight** _____
Who is your primary care provider? _____
Pharmacy _____ **Phone #**_____
(ONLY ONE PLEASE)

What is the main reason for your visit? (☑ pick up to two)

□ Colon Cancer Screening	□ Chest pain	□ Fever	□ Rash
□ Abdominal pain	□ Confusion	□ Flatulence (Gas)	□ Rectal Bleeding
□ Abdominal swelling	□ Constipation	□ Heartburn/Reflux	□ Speech Difficulty
□ Anal itching	□ Cough	□ Hoarseness	□ Tarry/Black Stool
□ Anal/Rectal pain	□ Depression	□ Incontinence	□ Vomiting
□ Back pain	□ Diarrhea	□ Itching	□ Weakness
□ Bad breath	□ Difficult Swallowing	□ Jaundice	□ Weight Gain
□ Belching	□ Edema	□ Nausea	□ Weight Loss
□ Bloating	□ Fatigue	□ Obesity	□ Wheezing

Medical Problems (☑ if yes)

□ Arthritis	□ Crohn's disease	□ Heart murmur	□ Rheumatic fever
□ Artificial Heart Valve	□ Depression	□ Hepatitis	□ Seizures
□ Alzheimer's Disease	□ Diabetes	□ High blood pressure	□ Ulcer Disease
□ Anemia	□ Fibromyalgia	□ HIV or AIDS	□ Stroke
□ Asthma/Bronchitis	□ Gallstones	□ Irritable bowel	□ Thyroid disease
□ Bleeding problems	□ Glaucoma	□ Kidney disease	□ Tuberculosis
□ Cancer type_____	□ Heart disease	□ Parkinson's	□ Ulcerative colitis
□ Colon cancer	□ History of colon polyps	□ Reflux disease	□ Defibrillator
□ COPD/Emphysema			
□ Other medical problems:			

Allergies and Reactions

Allergic to Latex? Y□ N□

Please list all Allergies and Reactions (Medications, foods and Environment):

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Surgeries/Hospitalizations (and dates)

1._____ 3._____
2._____ 4._____

Have you ever had a flexible sigmoidoscopy? Y□ N□ **If Yes, please give the date** _____
Have you ever had a colonoscopy? Y□ N□ **If Yes, please give the date** _____
Have you ever had an upper endoscopy? Y□ N□ **If Yes, please give the date** _____

Name _____

List your current medications and doses (including over the counter)

Please leave "Last Dose" column blank if you have a procedure. The nurse will assist you with this section.

1._____Dosage_____Last Dose_____

2._____Dosage_____Last Dose_____

3._____Dosage_____Last Dose_____

4._____Dosage_____Last Dose_____

5._____Dosage_____Last Dose_____

If you need to add additional medication please ask front desk for an additional sheet of paper

PATIENT CURRENT REVIEW OF SYSTEMS

Constitutional

Chills	Y☐ N☐
Fever	Y☐ N☐
Feeling Tired	Y☐ N☐
Recent Weight Gain	Y☐ N☐
Recent Weight Loss	Y☐ N☐
Pregnant	Y☐ N☐

Eyes

Blurred Vision	Y☐ N☐
Glaucoma	Y☐ N☐
Contacts or Glasses	Y☐ N☐

Ears/Nose/Mouth/Throat

Hearing Aid	Y☐ N☐
Hoarseness	Y☐ N☐
Nose Bleeds	Y☐ N☐
Sinus Problems	Y☐ N☐
Sore Throat	Y☐ N☐

Cardiovascular

Chest Pain	Y☐ N☐
Irregular Heart Beats	Y☐ N☐
Shortness of Breath	Y☐ N☐
Swelling of Ankles	Y☐ N☐
Pacemaker	Y☐ N☐
Defibrillator	Y☐ N☐
Stents	Y☐ N☐

Neurological

Brain/Spinal Injury	Y☐ N☐
Confused	Y☐ N☐
Fainting	Y☐ N☐
Headaches	Y☐ N☐

Gastrointestinal (Symptoms within the past year)

Abdominal Pain	Y☐ N☐
Abdominal Swelling	Y☐ N☐
Anal Itching	Y☐ N☐
Anal Pain/Sore	Y☐ N☐
Appetite Loss	Y☐ N☐
Belching	Y☐ N☐
Bloating	Y☐ N☐
Constipation	Y☐ N☐
Change in bowel habit	Y☐ N☐
Diarrhea	Y☐ N☐
Difficulty Swallowing	Y☐ N☐
Get full easily	Y☐ N☐
Heartburn/Reflux	Y☐ N☐
Incontinence of Stool	Y☐ N☐
Nausea	Y☐ N☐
Pain on Swallowing	Y☐ N☐
Pain when Defecating	Y☐ N☐
Vomiting	Y☐ N☐

GI Bleeding

Black / Tarry Stool	Y☐ N☐
Maroon Stool	Y☐ N☐
Rectal Bleeding	Y☐ N☐
Vomiting Blood	Y☐ N☐
Vomiting 'Coffee Grounds'	Y☐ N☐

Airway

Sleep Apnea	Y☐ N☐
Use C-PAP	Y☐ N☐
Difficulty Opening Mouth	Y☐ N☐
Difficulty Turning	

Respiratory

Chronic Cough	Y☐ N☐
Wheezing	Y☐ N☐
Positive TB Skin Test	Y☐ N☐
Use Oxygen @ Home	Y☐ N☐

Genitourinary

Blood in Urine	Y☐ N☐
Frequent Urination	Y☐ N☐
Incontinence	Y☐ N☐

Musculoskeletal

Back Pain	Y☐ N☐
Joint Pain	Y☐ N☐
Joint Replacements	Y☐ N☐
Joint Swelling	Y☐ N☐
Muscle Pain	Y☐ N☐

Psychiatric

Anxiety	Y☐ N☐
Depression	Y☐ N☐

Integumentary (Skin)

Itching	Y☐ N☐
Rash	Y☐ N☐
Skin Ulcers	Y☐ N☐

Hematological

Anemia	Y☐ N☐
Easy Bleeding / Bruising	Y☐ N☐
Past Blood Transfusion	Y☐ N☐

Name _____

Weakness/Numbness Y□ N□ Head Y□ N□

Immunizations and vaccinations

Have you ever had a Pneumonia Vaccination? Y□ N□ If Yes, please give the date _____

Have you had an Influenza Vaccination in the last year? Y□ N□ If Yes, please give the date _____

Social history and habits

Married? Y□ N□ Current occupation _____

Children? Y□ N□ Ages _____

Do you smoke or chew tobacco? Y□ N□ How Much? _____

Do you drink alcohol? Y□ N□ How much and how often? _____

Have you ever used street drugs or recreational drugs? _____

Family history

Father: Age _____ Living – Illness_____ Deceased – Cause of Death_____

Mother: Age_____ Living – Illness _____Deceased – Cause of Death_____

Brothers: Number_____ Any illnesses? _____

Sisters: Number_____ Any illnesses? _____

Have any of your close relatives (parents, grandparents, brothers, sisters, children) had: (☑ if yes)

□ Bleeding disorders	□ Crohn's disease	□ Liver disease
□ Cancer type _____	□ Diabetes	□ Pancreatitis
□ Colon cancer? Who_____	□ Gallstones	□ Stomach ulcer
□ Colon polyps? Who_____	□ Heart Disease	□ Ulcerative colitis
□ Other diseases:		

Other Pertinent Information_____

_____

_____

_____

_____

Patient Signature: _____ **Date**: _____

If you are scheduled for a colonoscopy, flexible sigmoidoscopy or EGD, the information on this form must be updated within 30 days of having the procedure.
(This update can be done on the day of the procedure.)

Please check one of the following boxes:

I have reviewed this form; there are: □ no changes □ changes

If changes, please list:_____

_____

_____

_____

_____

Patient Signature: _____ **Date**: _____

Form Reviewed by_____ Date _____

Form Reviewed by_____ Date _____

Carolina Endoscopy Center
Patient Financial Responsibility Agreement

In order for Carolina 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 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.
  ****If this is not possible, you agree to contact our Business Office BEFORE services are rendered.*

- **To provide us with a copy of your most recent insurance card** or other proof of insurance at the time of service.
  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 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 the Center to resolve the unpaid status of your account.**

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

- **That unpaid bills older than 90 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.**

For your information, please be informed that Carolina Digestive Health Associates, P.A. has a significant ownership interest in the endoscopy center where you are having your procedure performed, and accordingly the physician-shareholders of Carolina Digestive Health Associates, P.A. are indirect owners of the endoscopy center.

Patient or Guarantor Signature_____Date_____
By my signature above, I understand and agree to the above provisions.

Rev: September 2008

Carolina Endoscopy Centers

Monroe Center

High Quality, Cost-Effective GI Services, Colonoscopies & EGDs

Thank you for your interest in the Monroe location of Carolina Endoscopy Centers. As a valued patient, you will receive cost-effective GI services and quality care at our facility.

We work with all major insurance carriers and provide reasonable self-pay terms. Our flexible scheduling offers the care you need, when you need it.

Carolina Endoscopy Centers provide the convenience and access of an outpatient care center close to you, while ensuring the highest quality patient care available.

Our Centers are fully accredited and licensed in the state of North Carolina. Visit our web site for more information about our services and locations near you.

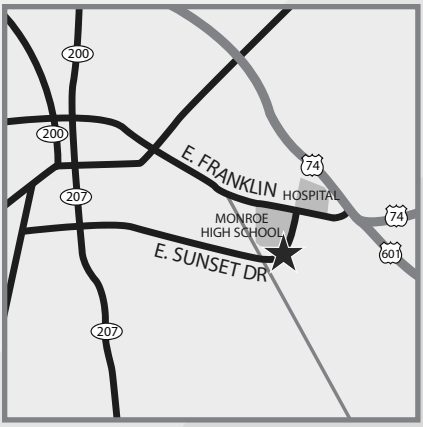
ASGE Quality
ENDOSCOPY UNIT RECOGNITION PROGRAM

Carolina Endoscopy Centers

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

CarolinaEndoscopyCenters.com

1321 East Sunset Drive
Monroe NC 28112
Ph 704.261.1220



Monroe
Endo Center Map
& Driving Directions

From the North:
- **Head South on Concord Hwy / US-601**
- **Turn right onto US-74 E ramp**
- **Merge onto US-74 E**
- **Turn right at E Franklin St**
- **Turn left at E Sunset Dr**

From the East:
- **Head West on US-74 W**
- **Turn left at E Franklin St**
- **Turn left at E Sunset Dr**

From the West:
- **Head Northeast on Waxhaw Hwy / NC-75**
- **Continue on Waxhaw Hwy**
- **Continue on NC-75 / NC-84**
- **Continue on E Franklin St**
- **Turn right at E Sunset Dr**

About the Carolina Endoscopy Center Monroe

More affordable than hospital based procedures
Only licensed Outpatient Endoscopy Center in Union County
Accredited by AAAHC
Contracts with all major insurance carriers
Reasonable self-pay terms
Availability of deep sedation with Propofol
Open Access Screening Colonoscopy available
Free Wi-Fi access