DAY OF PROCEDURE CHECK LIST

DATE OF PROCEDURE:_____ **ARRIVAL TIME:**_____

(If arrival time is 6:30 a.m. – do not come earlier. Our doors open at 6:30 a.m.)

Please call the office 2 weeks prior to your scheduled appointment to update your information and have your prescription sent to the pharmacy. It is your responsibility to notify the office of ANY and/or ALL changes to your medications, address, phone number, and insurance, as well as an update on weight and height.

- ☐ **DID YOU GET WRITTEN PERMISSION AND STOP YOUR BLOOD THINNER PRIOR TO PROCEDURE AS RECOMMENDED BY YOUR PRESCRIBING DOCTOR.**
- ☐ **DID YOU COMPLETE YOUR PREP**
- ☐ **DID YOU STOP DRINKING ALL FLUIDS 3 HOURS BEFORE PROCEDURE**
- ☐ **NO GUM OR MINTS**
- ☐ **DO YOU HAVE A DRIVER WHO MUST REMAIN IN THE OFFICE WHILE YOU HAVE YOUR PROCEDURE**
- ☐ **IF YOU ARE A WOMAN OF CHILDBEARING YEARS, DO YOU HAVE A FULL BLADDER TO PROVIDE A URINE SAMPLE**
- ☐ **DID YOU COMPETELY FILL OUT YOUR PAPER WORK INCLUDING:**
    - ☐ **MEDICATIONS**
    - ☐ **PRIMARY DOCTOR**
    - ☐ **PRIMARY DOCTOR'S ADDRESS**
    - ☐ **PRIMARY DOCTOR'S PHONE/FAX #**

DiMARINO-KROOP-PRIETO GASTRO-INTESTINAL ASSOCIATES, P.A.

Anthony J. DiMarino, M.D.
Howard S. Kroop, M.D.
Jorge A. Prieto, M.D.
Mitchell I. Conn, M.D.
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132 South 10th Street
480 Main Building
Philadelphia, PA 19107
(215) 955-8900
FAX: (215) 923-3147

PATIENT INSTRUCTION SHEET – UPPER ENDOSCOPY

YOUR Upper Endoscopy will be performed in our surgical suite, which is attached to our office (South Jersey Endoscopy Center) unless otherwise instructed. YOUR PROCEDURE IS SCHEDULED FOR:

_____

Please check with your insurance company for any referrals or co-pays they may require. It is YOUR responsibility to obtain the necessary referrals. If you do not have a proper referral, your procedure WILL be cancelled.

The Preparation for your procedure requires that you have NOTHING TO EAT from MIDNIGHT until AFTER YOUR EXAMINATION THE NEXT DAY. You may have **CLEAR** LIQUIDS (clear sodas. Juices, clear sports drinks, NO red or purple.) **ONLY** up until 3 hours prior to your procedure.

PRE-PROCEDURE INSTRUCTIONS

- You can have **NOTHING TO EAT** after Midnight until after your examination is completed . You may have only **CLEAR LIQUIDS** until 3 hours prior to your procedure. Your procedure **WILL BE CANCELLED** if you consume liquids after that time period! Food or liquids in your stomach at the time of your procedure can put you at risk for serious complications.

- STOP any blood thinners (i.e. Coumadin, Plavix, Persantine) five (5) days prior to your examination. Please get approval to stop this medication from the physician who prescribed it. We have a letter explaining this process. Please request one from our office. Also, please tell the nurse that you have been on these medications before your test starts. YOU MUST bring us a letter from your cardiologist.

- If you have taken **Antibiotics** for a procedure in the past, please call the office as you may need antibiotics again.

- DO NOT stop any heart or blood pressure medication. Take them with a small sip of water on the morning of your test.

- IF YOU HAVE A DEFIBRILLATOR – YOU MUST NOTIFY YOUR CARDIOLOGIST AND GET A LETTER OF CARDIAC CLEARANCE FOR THIS PROCEDURE. We will also need, included in that letter, information regarding the type and model of your defibrillator. We must know whether it can be turned off with a magnet. ***Your procedure will be cancelled if we do not receive this information prior to your procedure.***

- If you are an insulin dependant diabetic, please contact your physician for the amount of insulin to be taken on the day before an on the day of your procedure. The amount of insulin to be taken per your doctor is: _____.

- Bring completed packet with you on the day of your procedure – which includes a list of your medications.
- Call our office immediately with any change of insurance information that may occur prior to your procedure.
- Do Not chew gum, have mints, etc. after midnight on the night before your procedure.

PEOPLE'S RIGHTS AS PATIENTS
PATIENT/CLIENT BILL OF RIGHTS

DiMarino-Kroop-Prieto Gastro-Intestinal Assoc., P.A. adopts and affirms as departmental policy the following rights of patients/clients who receive services from our directly operated or contracted agencies. This policy affords you, the patient/client, the right to:

1. Be treated with respect, consideration and dignity.
2. Receive, upon request, the name of the person in charge of your care.
3. The name and function of any person providing services to you.
4. Obtain from the person responsible for your health care complete current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information will be made available to an appropriate person in your behalf.
5. Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other possible treatment methods, if any.
6. Refuse treatment and to be informed of the medical or other consequences of your action.
7. Privacy to the extent consistent with adequate medical care. Case discussion consultation, examination and treatment are confidential and should be conducted discreetly.
8. Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party contract.
9. A reasonable response to your request for services customarily rendered by this facility, and consistent with your treatment.
10. Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
11. The identity, upon request, of all health care personnel and healthcare institutions authorized to assist in your treatment.
12. Refuse to participate in research. Human experimentation affecting care or treatment shall be performed only with your informed consent.
13. Upon request, examine and receive an itemized explanation of your bill, regardless of source of payment.
14. Know the facility's rules and regulations that apply to your conduct as a patient.
15. Treatment without discrimination as to race, color, religion, sex, national origin, source of payment, political belief or handicap.
16. Expect that reasonable efforts will be taken to accommodate the rights of the non-smoking patient.
17. Expect your reports of pain to be believed and receive information about pain and pain relief measures, with a concerned staff committed to pain prevention and management and health professionals who respond quickly to reports of pain.
18. Change specialty physician if other qualified physicians are available or request a second opinion.

To File a Complaint to Medicare: Medicare Beneficiary Helpline 1-800-6244557 TTY Users 1-800-752-8420 8:30 AM to 5 PM Mon. through Fri.
www.medicare/gov Ombudsman

To File a Complaint about a Health Care Facility: N.J. Dept. of Health & Senior Services 24 hr. Hotline 1-800-792-9770
Practice Manager
Barbara Fargnoli (any concerns please contact Sherri Garbowski, RN)

Or write to: N.J. Dept. of Health and Senior Services
Div. Of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, N.J. 08625-0367

PATIENT RESPONSIBILITIES

Provision of Information

A patient has the responsibility to provide accurate and complete information about their medical condition and health history.

A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

A patient is expected to ask the doctor or nurse what to expect regarding pain management and to discuss pain relief options with your providers and nurses and to work with them to develop a pain management plan and to ask for pain relief when pain first begins.

Compliance with Instructions

A patient is responsible for following the treatment plan recommended by their practitioner(s) for his/her care.

Refusal of Treatment

The patient is responsible for his/her actions if he /she refuses treatment or does not follow the practitioner(s) instructions.

Respect and Consideration

The patient is responsible for being considerate of the rights of other patients and office personnel, and for assisting in the control of noise and not smoking. The patient is responsible for being respectful of the property of other persons and of the office.

SOUTH JERSEY ENDOSCOPY CENTER

26 E. RED BANK AVE, WOODBURY, NJ 08096 · 856-848-4464

PRE-PROCEDURE PERSONAL INFORMATION FORM

PLEASE COMPLETE AND BRING THIS PACKET WITH YOU ON THE DAY OF YOUR PROCEDURE

Patient Name:_____ Date of Procedure:_____

Medication Allergies:_____Age:_____ Height:_____

MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	Quantity

- Please attach separate page if needed.

SOCIAL HISTORY: Do you smoke: □YES □NO If yes, how many per day:_____How many years:_____

PREP USED: □ Gallon □ Half-Lytely □ SUPREP □ Prepopik □ MOVI-Prep □ Miralax

Were you able to complete you preparation? □ YES □ NO □ OTHER:_____

Do you have any loose, broken or chipped teeth or crowns that are not secure? □ YES □ NO

Name and phone number of person who will be responsible for accompanying and assisting you with any questions, help in dressing or other assistance as required. Please note: this person **MUST** remain here in our office during your procedure and be able to drive you home:_____

Do you give permission for this person to be with you when the doctor goes over your results? □ YES □ NO

Phone number where you can be reached the business day after your procedure so we may follow-up with your care. _____.

PRIMARY DOCTOR'S NAME AND ADDRESS:_____

South Jersey Endoscopy is owned solely by the Corporation or DiMarino-Kroop-Prieto Gastro-Intestinal Associates, PA.

□ I have received a copy of the Rights of Patients, Patient Responsibilities and a request for Advance Directive and information of ownership.

Patient Signature:_____Date:_____Time:_____

Reviewed By:_____ Date:_____Time:_____

Revised: 1/13/15

DIMARINO – KROOP – PRIETO GASTRO-INTESTINAL ASSOCIATES, P.A.
SOUTH JERSEY ENDOSCOPY CENTER
26 Red Bank Ave, Woodbury, NJ 08096
856-848-4464

WAIVER FORM

Account #_____

I realize that my procedure will be performed at SOUTH JERSEY ENDOSCOPY CENTER, AN APPROVED Ambulatory Surgical Center. I understand that my insurance will be billed for both a professional fee from DiMarino-Kroop-Prieto-Gastrointestinal Associates, P.A. and a room fee from South Jersey Endoscopy Center. I will also be receiving MAC anesthesia from an Anesthesiologist which will be billed separately. I also understand that I shall be responsible for any balances that my insurance may not cover, including deductibles and co-pays that may apply if my insurance is not contracted with this Ambulatory Service Center.

Print Name: _____

Signature: _____ Date: _____

IMPORTANT INFORMATION ABOUT BIOPSIES

During your procedure, it may be necessary to obtain a biopsy. SOUTH JERSEY ENDOSCOPY CENTER sends all the biopsy specimens to MIRACA DIAGNOSTICS. Miraca participates with all insurance companies. It is possible you will receive an "explanation of benefits" from your insurance company stating that you may receive a bill from Miraca. This is not a bill. We have made special arrangements with Miraca on your behalf, and you should not receive a bill, with the exception of any co-pays or deductibles that would normally be your responsibility. You may be billed from Miraca for that amount, and this would be your responsibility.

Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO OUR RECEPTIONIST ON THE DAY OF YOUR PROCEDURE. THANK YOU!

SOUTH JERSEY ENDOSCOPY CENTER
26 E. Red Bank Avenue
Woodbury, NJ 08096

Name:

Date of Birth:

ESOPHAGOGASTRODUODENOSCOPY

1. I hereby authorize Dr. _____ to perform the following procedure:

   _____.

2. I understand that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedures than those set forth in Paragraph one. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as are necessary and desirable in the exercise of their professional judgment.

3. I acknowledge that the available anesthesia options have been explained to me along with the benefits and attendant risks. I consent to the administration of the following type of anesthesia/sedation to be applied by or under the direction of my physician:

   ☐ Moderate Sedation ☐ Local Anesthesia

4. A physician member of the Anesthesiology Department will obtain consent for any additional anesthesia required. I understand that during the course of a procedure, unforeseen changes in my condition may arise which would necessitate a change in the care being provided to me. Should such an instance arise, I permit the anesthesiologist to provide treatment, which he/she deems necessary for my safety and well being.

5. Dr. _____ has fully explained to me the nature and the purpose of the procedure(s), its benefits, possible alternative methods of diagnosis or treatment, the risks involved, the possibility of complications, the foreseeable consequences of the procedure(s) and the possible results of non-treatment. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

   Specifically the risks identified to me include but are not limited to the following: Mild abdominal discomfort, bloating, cramping, sore throat, and irritation and bruising at the intravenous site. Other complications occurring less than 1 in 1000 exams include bleeding, tear in the lining of the GI tract requiring surgery to repair, aspiration of the stomach contents, serious problems with heart and lung function, and damage to the mouth, teeth, or vocal cords.

6. I hereby allow authorized representatives of DiMarino-Kroop-Prieto GI Assoc. to examine or photograph portions of my body, and use dismembered tissue for education, medical research or development purpose(s), and dispose of tissue which may be removed by a physician(s) as necessary for my diagnosis/treatment.

7. I certify that I have read and fully understand the above consent statement. In addition, I have been afforded an opportunity to ask whatever questions I might have regarding the procedure(s) to be performed and they have been answered to my satisfaction.

_____ _____ am/pm

Patient/Authorized Representative (state relationship to Patient) | Date | Time

_____ _____ am/pm

Witness Signature | Date | Time

I certify that I have explained the risks, benefits and alternatives of this treatment to the patient or his/her surrogate, and have answered all of his/her questions.

_____ _____ am/pm

Physician Signature | Date | Time

I certify that the above signature was made by me on the date noted:

_____ _____

Patient's Signature | Date Signed (Should be date of procedure)

_____

Witness

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PROCEDURE CANCELATION/DRIVER AGREEMENT

I, _____, fully understand the verbal and written procedure instructions given to me today. I will contact your office before my procedure if I have any questions about this information or about the consent form.

We will attempt to confirm this appointment 3 days prior to your procedure, however, if we do not reach you personally, **YOU MUST CONFIRM THE APPOINTMENT TWO DAYS PRIOR OR IT MAY BE CANCELLED.**

YOU MUST ALSO **GIVE 48 HOURS NOTICE** IF CANCELLING YOUR APPOINTMENT (WEEKENDS DO NOT COUNT IN THE 48 HOURS) OR **YOU WILL BE CHARGED $100.00 CANCELLATION FEE.**

I agree to inform my driver that he/she MUST drive me here, remain in the waiting room for the entire length of my stay in this facility, and drive me home. The procedure will not start and be cancelled if your driver does not agree to these rules.

Patient's Signature _____

Witness _____

Procedure _____ Date of Procedure _____

Date signed _____