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.
Robert M. Coben, M.D.
Jeffrey A. Abrams, M.D.
Michael C. DiMarino, M.D.
Nicholas T. Orfanidis, M.D.
Aarati B. Malliah, M.D.
Lisa R. Rahaim, APN,C

Woodbury Medical Plaza
26 East Red Bank Avenue
Woodbury, NJ 08096
(856) 848-4464
FAX: (856) 848-8706

Thomas Jefferson University Hospital
132 South 10th Street
480 Main Building
Philadelphia, PA 19107
(215) 955-8900
FAX: (215) 923-3447

FLEXIBLE SIGMOIDOSCOPY WITH SEDATION

DATE OF EXAMINATION: _____ ARRIVAL TIME: _____

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.

Please follow the instructions below. If you have any questions, please contact our office several days prior to your procedure.

TO PURCHASE AT LEAST TWO DAYS PRIOR TO YOUR TEST:

- 1 Bottle of Magnesium Citrate (can be purchased at most drug and grocery stores).
- 1 fleet enema

On the day before your test:

1. Eat a regular breakfast and lunch
2. Clear liquids only after lunch (have lunch no later than 2 PM)
3. At 6:00 PM on the evening before the examination – drink 1 bottle of Magnesium Citrate
4. You may have clear liquids up to 3 hours before your procedure. You can have nothing to eat after lunch the day before your procedure. If you do not follow this instruction, your procedure WILL be cancelled. Food or liquids in your stomach at the time of your procedure can put you at risk for serious complications.

On the morning of your test:

1. Two hours prior to your examination, take a fleet enema.

OTHER IMPORTANT INSTRUCTIONS

- STOP BLOOD THINNERS (i.e. - Coumadin, Plavix, Persantine) 5 days prior to your examination. Please get approval to stop this medication from the physician who prescribed it. You must get a note from them saying it was permissible for you to stop this medication. We have a note explaining what we require if you need it. We must receive the note at least one day prior to your procedure. Also, please tell the nurse that you have been on these medications before the test starts. If you have any questions, please feel free to contact our office.

- 2 Days prior to your procedure: call our office to confirm your appointment. It is YOUR responsibility to confirm this appointment. We will attempt to call you 3 days prior to confirm your appointment, but in case we do not reach you, please call us! Your procedure may be cancelled if we do not confirm your appointment.

- You MUST have someone accompany you on the day of the procedure. This person MUST remain here during your procedure, and will be required to sign a statement saying they will do so. You should be comfortable with this person, as they may need to assist you with dressing after your procedure, and also the doctor may have need to ask this person some questions. THIS IS A NEW REQUIREMENT AND IS MANDATORY!

- If you have a DEFIBRILLATOR – PLEASE NOTIFY YOUR PHYSICIAN IMMEDIATELY.

- If you are an Insulin dependant diabetic, please contact your physician for the amount of insulin to be taken on the day before, and on the day of your procedure.

- DO NOT STOP ANY HEART OR BLOOD PRESSURE MEDICATION. Take them with a sip of water on the morning of your test.

- Please bring this written and completed packet with you, which includes a written medication list (not the empty container).

- YOU MAY HAVE CLEAR LIQUIDS ONLY UP TO THREE HOURS BEFORE YOUR PROCEDURE. Food or liquids in your stomach at the time of your procedure can put you at risk for serious complications.

- DO NOT chew gum, have mints, etc. after midnight on the night before your procedure.

- It is your responsibility to get a referral, if your insurance requires it. A referral is different from a prior authorization. We will take care of any prior auth needed. If your insurance requires a facility co-pay, you will be expected to pay this when you arrive the day of your procedure.

IF YOU HAVE ANY DIFFICULTY WITH YOUR PREPARATION ON THE EVENING BEFORE YOUR TEST - CALL 856-573-7543. You will reach an operator. Please notify them that you are having a procedure the next day and are having problems with your preparation. A doctor will return your call and give you further instructions.

ADDITIONAL IMPORTANT INFORMATION

- ALL NAIL POLISH MUST BE REMOVED PRIOR TO PROCEDURE.
  - If you have artificial nails of any type – they do not have to be removed, just the nail polish.

- WOMEN OF CHILDBEARING YEARS – A pregnancy test may be required. If our anesthesiologist determines this test is necessary, you will be responsible for the cost of this procedure ($5.00)

- **IF YOU ARE TAKING COUMADIN -** You MUST stop this medication 5 days prior to your procedure. You MUST also get a letter from the doctor who prescribed it. Please ask the receptionist for a copy of the form which gives the needed criteria for this letter. WE WILL NOT Perform your procedure if you do not supply us with this authorization from your Cardiologist or Primary Care Physician.

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 aud 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

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 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 Gastrointestinal 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: 8/12/14

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!