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.

**** There is a $100.00 NO SHOW/LATE CANCELATION FEE. Please call 72 hours prior to your procedure if you are going to cancel your procedure.**

- ☐ YOU MUST TAKE ALL YOUR BLOOD PRESSURE AND HEART MEDICATIONS WITH A SIP OF WATER BEFORE ARRIVING FOR YOUR PROCEDURE.
- ☐ 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
- ☐ PLEASE REMOVE NAIL POLISH PRIOR TO 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 #
- ☐ COVID TESTING
- ☐ SELF QUARANTINE UNTIL AFTER PROCEDURE

CLEAR LIQUID DIET

THIS CLEAR LIQUID DIET IS MEANT TO BE FOLLOWED WHILE YOU ARE PREPARING FOR YOUR PROCEDURE. PLEASE FOLLOW THE PACKET OF INSTRUCTIONS YOU HAVE BEEN GIVEN FROM THE OFFICE.

LIQUIDS THAT ARE ALLOWED

> GATORADE

> JELLO

> ICED TEA

> POPSICLES

> WATER

> NON-COLA SODA (sprite, ginger ale)

> HOT COFFEE OR TEA (no cream!!)

> HARD CANDIES

> SUGAR (with beverages)

> APPLE JUICE (not cider)

> SWEET N LOW, ETC

> WHITE CRANBERRY JUICE

> HONEY (in tea)

> CLEAR CHICKEN OR BEEF BROTH

> WHITE GRAPE JUICE

> ENSURE CLEAR

LIQUIDS NOT ALLOWED

> NO RED, PURPLE PRODUCTS

> ABSOLUTELY NO SOLID FOOD

> NO ALCOHOLIC BEVERAGES

> NO MILK OR MILK DRINKS (includes powdered creamer)

> NO ORANGE JUICE OR CITRUS JUICE (if you can not see through the juice you may not have it)

ON THE DAY OF YOUR PROCEDURE

YOU ARE NOT TO DRINK ANYTHING 3 HOURS PRIOR TO YOUR PROCEDURE, NOT EVEN GUM CANDY OR MINTS!!!

FOR COLONOSCOPY PROCEDURES: YOU SHOULD NOT HAVE HAD ANY SOLID FOOD SINCE YOUR BREAKFAST THE DAY PRIOR TO YOUR TEST IF THIS IS NOT FOLLOWED YOUR PROCEDURE WILL BE CANCELED.

Miralax Prep Instructions- 6 Liter Dose

6 Liter High Dose Miralax-Gatorade

What you need to buy:

1) Gatorade: Six 32-ounce bottles (*not* red or orange)
    a. **Diabetics – buy sugar free Gatorade (Gatorade Zero)**
2) Miralax: A*t least* 24 ounces (you will need 42 regular doses which is 714 grams)
    a. Three 8.3-ounce jars *OR* Two 17.9-ounce jars OR One 26.9-ounce jar
3) Bisacodyl: 10 mg
    a. One 10 mg tablet *OR* two 5 mg tablets

How to prepare the Miralax-Gatorade preparation (morning the day *before* colonoscopy):

1) To **each** bottle of Gatorade, add 7 capfuls of Miralax powder
    a. You will use a total of 42 capfuls of Miralax (7 capfuls added to each 32-ounce Gatorade bottle)
2) Thoroughly mix so there is no visible powder in each Miralax-Gatorade bottle
3) Place the six 32-ounce Miralax-Gatorade bottles in the refrigerator

When to take the Miralax-Gatorade preparation (day before AND morning of colonoscopy):

1) The day before the colonoscopy
    a. Remember, **ONLY** clear liquids the entire day before the colonoscopy
    b. At **3 PM**, take 10 mg of bisacodyl
    c. At **4 PM**, drink two 32-ounce Miralax-Gatorade bottles over 2 hours
    d. At **7 PM**, drink two 32-ounce Miralax-Gatorade bottles over 2 hours
2) The day of the colonoscopy
    a. **5 hours before the colonoscopy**, drink two 32-ounce Miralax-Gatorade bottles over 2 hours
    b. Remember, nothing to drink for 3 hours before colonoscopy except sips of water with medications

Please Read the following for additions information prior to your procedure

Date of procedure:_____

Arrival time:_____
If your arrival time is 6:30am-do not arrive any earlier. Our doors open at 6:30am

Procedure Time:_____

> **All women of child bearing years**-a pregnancy test may be required. If our anesthesiologist determines this test is necessary you may be responsible for the cost of this test. ($15.00)

> **PLEASE NO NAIL POLISH!!!** - Please make sure to remove nail polish on **ALL** of your nails prior to your appointment.

> **If you have a defibrillator**-you must notify your cardiologist and get a letter of cardiac clearance for this procedure. We will also need the make and model number of your defibrillator. Please inform the office if you do have this device.

>You MUST have someone accompany you the day of your procedure. You will be sedated and **WILL NOT** be permitted to leave here unescorted. This person **MUST** remain here during your procedure. You should be comfortable with this person as they may need to help you with dressing after the procedure. **You and your driver will be required to sign a statement stating that they will remain in the office during your procedure.**

> **STOP BLOOD THINNERS** (i.e. coumadin, Plavix etc.) 2-5 days prior to your procedure. Your cardiologist will determine the amount of time you need to stop your blood thinner prior to your procedure. **You must get written approval from your doctor that it is permissible for you to stop your medication**. Also, please tell the nurse that you are on these medications before the test starts. If you have any questions/concerns please 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 contact 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!**

> If you are diabetic, please contact your physician for the amount of medication/insulin to be taken on the day before and the day of your procedure.

>DO NOT STOP ANY HEART OF BLOOD PRESSURE MEDICATION! Take them with a small sip of water the morning of your test

> **Please bring this packet with you**. Please complete all pages in this packet.

> **YOU MAY HAVE CLEAR LIQUIDS UP UNTIL 3 HOURS PRIOR TO YOUR PROCEDURE, AFTER THAT YOU ARE NOT TO HAVE ANYTHING BY MOUTH, THIS INCLUDES GUM, WATER, MINTS!!!!** Food or liquids in the stomach can put you at serious risk for severe complications.

> **IT IS YOUR RESPONSIBILITY TO GET A REFERRAL!** If your insurance requires referrals please obtain one prior to your appointment. A referral is different than a prior-authorization. We will take care of any prior authorization 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 after hours please call: 856-848-4464

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, and 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 TIY Users l-800-752-8420 8:30AM to 5 PM Mon. through Fri.

To File a Complaint about a Health Care Facility: N.J. Dept. of Health & Senior Services 24 hr. Hotline 1-800-792-9770
Or write to: N.J. Dept. of Health and Senior Services
Division Of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, N.J. 08625-0367

Office contact for any concerns: Michele Mikula, Nursing Manager
26 East Red Bank Ave
Woodbury, NJ 08098
856-848-4464

DiMarino Kroop Prieto Gastro-Intestinal Associates, P.A.
South Jersey Endoscopy Center
26 E. Red Bank Avenue, Woodbury, NJ 08096

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.

Transportation

A patient has the responsibility to provide a responsible adult to transport from the facility after a procedure or if required by the practitioner.

Finances

The patient is expected to accept personal financial responsibility for any charges not covered by his/her insurance. That includes all co-pays and deductible.

Patient Belongings and Valuables

The patient is responsible for their belongings and valuables. We ask that you leave all valuables home or with your driver. We do take not responsibility or reimburse for any patient lost items or valuables.

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:_____

ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING, OVER THE COUNTER MEDICATIONS & NATURAL REMEDIES/HERBS

Name of Medication	Dosage	Quantity

- Please attach separate page if needed.

FEMALES ONLY: Have you had your menstrual cycle in the last year? □ YES □ NO

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

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

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: 8/27/2020

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 INFORM DIAGNOSTICS. Inform Diagnostics 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 Inform Diagnostics. This is not a bill. We have made special arrangements with Inform Diagnostics 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 Inform Diagnostics for that amount, and this would be your responsibility.

Occasionally, the doctor might take an additional specialized biopsy called WATS3D and refer your sample to CDx Diagnostics. WATS3D is included in the ASGE Standard of Practice Guidelines for the screening and surveillance of Barrett's Esophagus. CDx Diagnostics bills all insurances. It is possible you will receive an "explanation of benefits" from your insurance company stating that you may receive a bill from CDX Diagnostics. This is not a bill. For in-network insurances, responsibilities for standard co-pays or deductibles apply. For out-of-network insurances, patients will not be responsible for amounts not covered by insurance.

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

COLONOSCOPY WITH POSSIBLE POLYPECTOMY
CONSENT FORM

Name:_____ Date of Birth:_____

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.
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 wellbeing.
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 and, 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, irritation, and bruising at the intravenous site. A tear in the wall of the colon that requires urgent surgery occurs in 1 in 2,000 colonoscopies. If a polypectomy is performed, the risk of a tear is 10 in 1,000 and the risk of bleeding is 25 in 1,000. Bleeding rarely occurs following biopsies. Blood transfusions may be necessary. Other complications occurring less than 1 in 2,500 colonoscopies include adverse drug reactions, aspiration of stomach contents, injury to the spleen, and serious problems with heart and lung function. Death has been reported to follow I in 5,000 colonoscopies. ***Colonoscopy is not a perfect examination of the colon and a negative***

examination does not definitively exclude the presence of abnormalities including colon cancer.

6. I hereby allow authorized representatives of DiMarino-Kroop-Prieto GI Associates, PA, 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	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 I 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:

_____	_____	_____am/pm
Patient/Authorized Representative	Date	Time

_____

Witness Signature