



# EndoCentre

## **Procedure Cost**


The cost of your procedure is dependent on your specific health insurance plan and your coverage benefits. It can also depend on your medical situation and the procedure that the physician recommends. If you have a high deductible plan, you may experience the maximum out of pocket cost.


We recommend that you call your insurance company to determine your financial responsibility. In addition, our billing & insurance department will contact your insurance company 3 days before your procedure to determine your portion of the cost.

We will give you the cost estimate information when we speak to you to confirm your procedure or you may call our billing department at 410-602-9343. As stated above, your financial responsibility will be an estimate and may change based on the actual medical situation.

Patients are required to bring their payment with them at the time of their procedure. Patient can also prearrange for a payment plan by calling 410-602-9343. Payment may be made by cash, check or credit card.

Thank you.

 **EndoCentre of Baltimore**  
1838 Greene Tree Road, Suite 180  
Baltimore, MD 21208  
Phone: 410-602-7782 / Fax: 410-602-9345

 **EndoCentre at Quarterfield Station**  
7704 Quarterfield Road, Suite I  
Glen Burnie, MD 21061  
Phone: 410-863-4899 / Fax: 410-484-9375

Please read, fill out and sign all forms.  
**DO NOT DATE.** Bring completed forms with you the day of procedure. Questions will be answered then.

Dear Patient:

You are scheduled for an appointment at the EndoCentre. Please note that nothing by mouth after midnight includes gum, mints and hard candy. You can brush your teeth before your procedure just don't swallow. We ask that you arrive **30 minutes prior** to your scheduled time. We ask that you do not wear jewelry or bring any valuables with you the day of your procedure. We are not responsible for the loss or damage to any valuables, jewelry or belongings.

Unless your physician has told you otherwise, you will be receiving **Anesthesia** for your procedure. **YOU MUST HAVE A RESPONSIBLE ADULT WITH YOU, TO DRIVE AND ESCORT YOU HOME,** following the procedure. Your responsible adult must come into the Suite to sign a paper before you will be released for discharge. Due to allergies and medical conditions of others, we ask that patients and escorts **refrain from wearing perfumes and cologne.**

**PRE-ADMISSION TESTING:** If you were given pre-admission test orders by your Gastroenterologist, please take them to your Primary Care Doctor and have them fax the test results to us **as soon as possible.**

EndoCentre of Baltimore Fax: 410-602-9345

EndoCentre at Quarterfield Station Fax: 410-484-9375

**BOWEL PREPARATION:** If your procedure requires **bowel preparation**, you have received those instructions from your physician or his/her secretary. It is very important that you follow the bowel prep instructions as directed. If you experience difficulty with the prep or have any questions, you must contact the physician's office. *If the office is not yet open, please ask answering service to contact the "on call" physician.*

#### **MEDICATIONS:**

- **Aspirin and Blood Thinners must be stopped 5 days prior to your procedure**, unless you received other instructions from your Primary Care Physician.
- Take **blood pressure, heart or seizure medication** on the morning of your procedure with a **small sip of water.**
- If you have been prescribed an inhaler for Asthma, **PLEASE BRING THE INHALER WITH YOU, EVEN IF YOU RARELY USE IT.**
- If you take **Insulin or Oral Diabetic Medication**, please follow your Primary Care/GI Physician's directions.
- **Diabetic patients that take Insulin**, please **test your blood sugar at home on the morning of your procedure.** If your reading is not within your normal range, *please notify your Primary Care/GI Physician. If the office is not yet open, please ask answering service to contact the "on call" physician.*

**INSURANCE INFORMATION:** We recommend that you contact your insurance company to see if there is anything special that needs to be addressed by our office. Managed Care patients may need a referral from your Primary Care Physician for the procedure. **BRING ALL INSURANCE CARDS AND PICTURE ID WITH YOU.** We will need to copy them at the EndoCentre.

**ADVANCE DIRECTIVES:** If you have **Advance Directives**, please bring a copy with you. It is our policy, in the event of an emergency situation, to transport you to the nearest hospital. Your copy of Advance Directives, if available, will be sent to the hospital and will be honored there.

**Cancellations made with less than 48 hours notice will be subject to a cancellation fee.**

We look forward to seeing you. If you have any questions, please contact your Gastroenterologist's office. Thank You.

Sincerely,

The EndoCentre Staff



## POST GI PROCEDURE INSTRUCTIONS (PRE-SEDATION)

- 1) It is not unusual to experience a sore throat temporarily (EGD) or a gaseous feeling after the procedure (colonoscopy).
- 2) Continue to rest at home for the completion of the day. Do not return to work until tomorrow, unless otherwise instructed by your physician.
- 3) No driving today (**NO EXCEPTIONS**), or other activities that may be affected by your altered perception due to the medication you received at the time of your procedure. You must have a driver present in the facility before you will be discharged.
- 4) No alcoholic beverages, narcotics or tranquilizers for twenty-four (24) hours unless you have checked with your physician.
- 5) You may experience some soreness or redness at the site of the needle in your arm (IV). Should these symptoms persist or spread, contact your physician.
- 6) Symptoms to watch for and report to your physician:
  - a. Severe abdominal pain or bloating
  - b. Chills or fever occurring within twenty-four (24) hours after the procedure
  - c. Pain in your chest
  - d. Severe abdominal pain, persistent bloating, nausea or vomiting
  - e. A large amount of rectal bleeding following a colonoscopy. A small amount of blood from the rectum is not serious, especially if hemorrhoids are present.
- 7) EGD, colonoscopy - Usually, there are no restrictions on the diet after these procedures unless specified by your own physician. In general, do not start eating or drinking until fully alert.

I, the undersigned, have read and understand the above instructions, before receiving any sedation.

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Patient Signature

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Date



## CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, \_\_\_\_\_, hereby authorize **EndoCentre** to use and/or disclose my health information which specifically identifies me or that which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign, **EndoCentre** can decline to treat me.

I have been informed that **EndoCentre** has prepared a Notice of Privacy Practices which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent, and that I may keep the copy of it if I choose.

I understand that I may revoke this consent at any time by notifying **EndoCentre** in writing, but should I do so, such revocation will not affect any actions that **EndoCentre** took before receiving my revocation.

I understand that **EndoCentre** has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

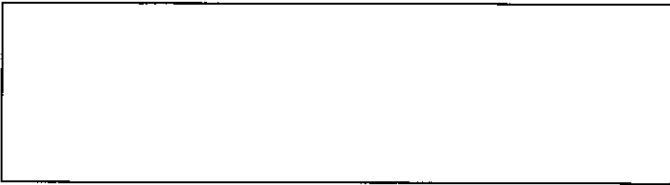
I understand that I have the right to request that **EndoCentre** restrict the manner in which my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **EndoCentre** does not have to agree to such restrictions, but that once such restrictions are agreed to, **EndoCentre** must adhere to such restrictions.

\_\_\_\_\_  
**Signature of patient or patient's representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of patient or patient's representative**

\_\_\_\_\_  
**Relationship to the patient**



## INFORMED CONSENT

### Principal Risks and Complications of Gastrointestinal Endoscopy

GI endoscopy is generally a low risk procedure, however, complications are possible no matter how careful one is. Your physician will discuss their frequency with you, if you desire, with particular reference to your own procedure.

- **Perforation:** The procedure may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs hospital admission and surgery may be required.
- **Bleeding:** Bleeding may occur. Management of this may consist only of careful observation but may require transfusions, endoscopic cautery, or possible surgery.
- **Risks of Sedation:** For your safety your heart rhythm, pulse, BP and oxygen measurement will be monitored. Possible complications of sedation include, but are not limited to, respiratory depression, disturbances of heart rhythm, decreased blood pressure, nausea and vomiting.
- **Medication Phlebitis:** Medications used for sedation may occasionally irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissues, which may persist for several weeks.
- **Other Risks:** Include but are not limited to: drug reactions and complications from other diseases you may already have. Instrument failure, infection and death are extremely rare, but remain remote possibilities.

### YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

**Alternative means of therapy** include but are not limited to x-ray studies and virtual examinations or surgery. Another option is to choose no diagnostic studies and/or treatment.

### DIAGNOSTIC/THERAPEUTIC PROCEDURES

Endoscopic examination and possible biopsy/polypectomy, cautery, injections, and/or dilatation if indicated.

UPPER GI ENDOSCOPY (EGD):	Examination of the esophagus, stomach, and duodenum.
COLONOSCOPY:	Examination of all or the major portion of the colon.
FLEXIBLE SIGMOIDOSCOPY:	Examination of the anus, rectum, and last part of the colon.
ESOPHAGEAL pH CAPSULE:	Attachment of capsule to esophageal wall to monitor pH level over 48 hours.
OTHER:	_____

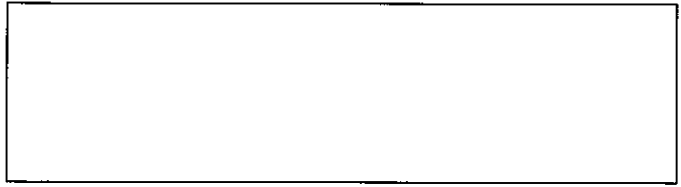
I certify that I have discussed with my physician and understand the information regarding these procedures. I have been fully informed of the risks and possible complications. I consent to the taking of biopsies and reproduction of any photographs taken in the course of this procedure for professional purposes. The proposed anesthetic plan has been discussed with me by an RN and/or Anesthesia Provider and my attending physician. I understand the procedures involved with their attendant risks, and consent to undergo the proposed anesthetic. I also understand that in the course of the procedure the anesthetic plan may need to be changed.

I hereby authorize and permit: \_\_\_\_\_ M.D. and his assistant(s) to perform the above procedures and to administer anesthesia as necessary during my procedure(s). If unforeseen condition(s) arise during my procedure(s) calling for additional procedures or medications (including anesthesia and blood transfusions), admission to the hospital or surgery, I further request and authorize him/her to do whatever he/she deems advisable in my interest. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s). There is a possibility of missed lesions, an incomplete procedure, and development of future lesions can occur. The policy of the EndoCentre regarding Advance Directives if an untoward event happens, is to stabilize all patients regardless of Advance Directives. Patients will then be transported to the hospital with a copy, if available, of Advance Directives that will be honored there.

I also understand that The EndoCentre is not responsible for any valuables that I chose to bring with me and I release them from any responsibility for loss or damage of any such valuables or belongings.

_____ Date	_____ Signature of Patient or Legal Guardian	_____ Signature of Physician
_____ Signature of Witness to Patient Signature	_____ Signature of Anesthesia Provider	

- The Patient/Legal Guardian has read this form or had it read to him/her.
- The Patient/Legal Guardian states that he/she understands this information.
- The Patient/Legal Guardian has no further questions.



## **PERMISSION FOR SHORT STAY ADMISSION**

I know that I have a health problem or have decided to undergo an elective endoscopic procedure that requires a diagnostic and/or therapeutic treatment.

Therefore, I voluntarily consent to my short stay admission and treatment at the EndoCentre.

I am aware that my gastroenterologist may have part ownership interest in the EndoCentre. If I choose to go to another health care facility for this procedure, it will not adversely affect my relationship with my gastroenterologist.

## **ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize the EndoCentre to apply for health insurance benefits on my behalf for covered services provided to me during my period of short stay admission. I request payment from my insurance company(s) be made directly to the EndoCentre.

I certify that the information I reported with regard to my insurance coverage is correct and I further authorize the release of any medical information necessary to process insurance claims related to this short stay admission.

I understand that I may receive separate bills for the procedure, the lab (if specimens taken) and anesthesia.

I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my or my dependent's behalf. This authorization may be revoked by me at anytime in writing.

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Signature of Patient

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Date

**Rights and Respect for Property and Person**

**The patient has the right to:**

- Exercise his or her rights without being subjected to discrimination or reprisal
- Voice grievances regarding treatment or care that is or fails to be furnished
- Be fully informed about a treatment or procedure and the expected outcome before it is performed
- Confidentiality of personal medical information

**Privacy and Safety**

**The patient has the right to:**

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

**Advance Directives**

**You have the right to information on the Center's policy regarding Advance Directives.**

Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

If you request, an official state Advance Directive Form will be provided to you.

**Submission and Investigation of Grievances:** You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

You may contact the Center Director at:

**EndoCentre of Baltimore- 410-602-7782**  
**EndoCentre at Quarterfield Station- 410-863-4899**

You may contact your state representative to report a complaint:

[www.chrmh.state.md.us/ohcq/](http://www.chrmh.state.md.us/ohcq/)

**Program Director**

**Office of Health Care Quality**

**55 Wade Avenue**

**Catonsville, MD 21228**

**1-800-492-6005**

**State website: [www.HHS.gov](http://www.HHS.gov)**

Sites for address and phone numbers of regulatory agencies: **Medicare Ombudsman website**

[www.medicare.gov/Ombudsman/resources.asp](http://www.medicare.gov/Ombudsman/resources.asp)

**Medicare: [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227)**

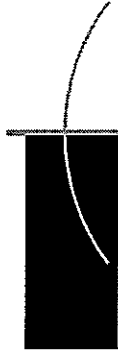
**Office of the Inspector General: <http://oig.hhs.gov>**

**Physician Financial Interest and Ownership:** The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

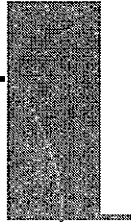
**By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.**

\_\_\_\_\_  
Signature of Patient or Patient Legal Representative

\_\_\_\_\_  
Date



# Patient Rights and Notification of Physician Ownership



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Glen Burnie, MD 21061  
410-863-4899

**PLEASE BRING THESE FORMS WITH YOU ON THE DAY OF YOUR PROCEDURE**

AS A PATIENT OF THE ENDOCENTRE, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF THE PROCEDURE.

**PATIENT'S BILL OF RIGHTS:**

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

**PATIENT RIGHTS:**

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery, and/or services.
- To be provided privacy and security of self and belongings during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

•When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

•To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.

•To be free from mental and physical abuse, free from exploitation, & free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

•Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

•Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

•Leave the facility even against the advice of his/her physician.

•Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.

•Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge for the facility.

•To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

•Know which facility rules and policies apply to his/her conduct while a patient.

•Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.

•To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his or her patient record.

•Examine and receive an explanation of his/her bill regardless of source of payment.

•To appropriate assessment and management of pain.

**If you need a translator:**

If you will need a translator, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.