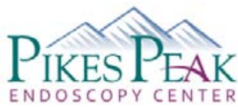
Please bring the following with you to your procedure

- ☐ Current insurance card (s)
- ☐ Photo ID
- ☐ Co-pay if applicable

The following Paperwork needs to be completed prior to procedure and brought with you

- ☐ Patient Information Sheet
- ☐ Authorization for procedure
- ☐ Patient consent to be contacted
- ☐ Acknowledgement of receipt of notice of privacy practices
- ☐ Notice of policy regarding advance directives
- ☐ Procedure financial disclosure
- ☐ Financial policy and patient agreement
- ☐ Online communication consent
- ☐ PPESC health questionnaire
- ☐ Patient medication form – **you must use the sheet attached** – please do not use a separate sheet unless you need additional space.



Procedure Financial Disclosure

You have been scheduled for a colonoscopy: CPT Code:___________ and/or an Upper Endoscopy (EGD):CPT: 43235 on ____________________ at

- ☐ Pikes Peak Endoscopy Center
- ☐ Briargate Endoscopy Center
- ☐ MemorialMain
- ☐ Memorial North

The indicating diagnosis for this procedure is ____. The diagnosis code(s) submitted on the claim for the procedure will indicate the actual findings of the procedure. (i.e., what may have been scheduled as a screening, could change to diagnostic due to the findings during the procedure.)

If you are having your procedure performed at Pikes Peak Endoscopy Center or Briargate Endoscopy Center, we are Medicare approved free-standing ambulatory surgical centers owned by the physicians of Gastroenterology Associates of Colorado Springs (GACS). **GACS physicians do not perform "office based" endoscopy services. Therefore, office visit co-pays will not apply for these services.**

Endoscopy services are surgical procedures and will be processed under the surgical provisions of your insurance plan. Some insurance plans have exclusions for out-patient surgical procedures or have different out-of-pocket expenses based on the location where the procedure is performed. Individual and Family deductibles may apply. While the procedures are diagnostic in nature, they are not considered a diagnostic test by the insurance carrier, nor the American Medical Association.

Our Pre-Cert Specialist will contact your insurance plan to see if pre-certification is required for the procedure. Please note that pre-certification is not a guarantee of payment as per your insurance company.

As a courtesy to our patients, we will attempt to find out what your benefits will be, however, all insurance companies specify that the information they provide to us does not guarantee payment or that the amounts they quote us due by the patient will be the same after the claim is processed. You are responsible for additional deductibles, co-pays or any co-insurance your insurance company may assess to your responsibility. Services not covered or deemed not medically necessary by your plan will be your responsibility. **We strongly encourage you to call your insurance carrier to understand what your benefits are for the procedure that has been scheduled.** We do have a cancellation policy and fee associated with the cancellation of procedures if we are not notified within the specified time period. It is your responsibility to understand what your coverage is and if you have questions regarding your coverage, you should contact your insurance company. You will need to provide them the information listed in the first section above. Be sure to have them review the "indicating" diagnosis as some plans have limited coverage based on diagnosis, or difference in coverage for screening vs. diagnostic procedures.

If you have not already done so, you will need to provide us with your correct insurance information at least 14 days prior to your scheduled procedure to allow time for pre-certification. You need to be sure we have your primary, secondary (and tertiary) insurance information as all may require pre-certification. Call (719) 632-7101, and follow the prompt for the appropriate physician that will be performing your procedure to report updated insurance information. Failure to report the correct updated insurance information prior to the procedure may result in you being responsible for the full balance due. If you present a different insurance at the time of check in for your procedure, your procedure may be rescheduled to a future date that allows us to complete the pre-certification process.

The procedure for which you are scheduled generates the following fees and will be billed separately: (1) a professional fee for the physician's services, (2) a facility fee for use of the surgery facility, and (3) if a tissue biopsy is required, a fee for pathology services from the pathologist/lab.

☐ **Please bring this signed form with you on the day of your procedure**

☐ **Please mail this form back to our office (address below) 4-5 days prior to your procedure**

Gastroenterology Associates of Colorado Springs, L.L. P./Pikes Peak Endoscopy and Surgery Center L.L.C./Briargate Endoscopy Center, L.L.C.

Acknowledgement of Receipt of Procedure Financial Disclosure

I have received a copy of the Procedure Financial Disclosure for Gastroenterology Associates of Colorado Springs, LLP.

______________________________ Patient Signature

______________ Date

______________________________ Print Name

PIKES PEAK ENDOSCOPY CENTER

GACS Gastroenterology Associates of Colorado Springs

BRIARGATE ENDOSCOPY CENTER

FINANCIAL POLICY AND PATIENT AGREEMENT

IMPORTANT – PLEASE READ

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Gastroenterology Associates of Colorado Springs, LLP, Pikes Peak Endoscopy & Surgery Center, LLC and Briargate Endoscopy Center, LLC. Please be advised that Pikes Peak Endoscopy & Surgery Center and Briargate Endoscopy Center are owned and operated by the physicians of Gastroenterology Associates of Colorado Springs, LLP and are Medicare approved and licensed by the state of Colorado.

APPOINTMENTS: Please arrive at least 30 minutes prior to your appointment to give yourself time to update your records or complete paperwork required by your insurance.

CANCELLATION POLICY: In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment so that we can accommodate another patient's needs. If you fail to cancel or reschedule in the appropriate amount of time the below fees will be applied to your account

- Office visits MUST be cancelled/rescheduled no later than **24 hours prior to your appointment; a $25.00 charge will be assessed if this does not occur**.
- Procedures (Colonoscopy/EGD) MUST be cancelled/rescheduled no later than **48 hours prior to your scheduled procedure; a $75.00 charge will be assessed if this does not occur.**

UNINSURED PATIENTS: Payment for services is **due in full** at the time of service or payment arrangements need to be made with our billing department **prior** to the service. For your convenience, we accept VISA, MasterCard, cash, checks and money orders.

INSURED PATIENTS: As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s). Please be aware that although we participate with most insurance companies, **it is your responsibility to make sure we are a participating provider with your plan.** If we have an agreement with your insurance carrier, we will receive direct payment for covered services. **Co-payments are due at the time of service**. Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. **You will be responsible for any remaining balance on your account once your insurance has processed our claim.**

Since your insurance policy is an agreement between you and the insurance carrier, we will not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care.

REFERRALS: If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and it is your responsibility to obtain one. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. If you are having a procedure performed at Pikes Peak Endoscopy & Surgery Center or Briargate Endoscopy Center and a pre-certification for that procedure is required, we will obtain authorization for that procedure on your behalf. If your insurance company does not authorize the procedure, you will be notified of your financial responsibility prior to the procedure being performed.

COPIES OF MEDICAL RECORDS: We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. We do not charge patients for copies of their own records. Fees for copying records requested from businesses are as follows: $14.00 for 10 or fewer pages, 50 cents per page for pages 11-40 and 33 cents per page after 40 pages.

ADDITIONAL CHARGES:

Missed Clinic Appointments	$25.00
Missed Procedure Appointments	$75.00
Returned Checks	$25.00

OVERPAYMENTS: We will not refund credit balances less than $10.00.

LATE PAYMENTS: Accounts 30 days or more past due will begin accruing finance charges.

COLLECTION AGENCY: We refer all unpaid accounts over 90 days past due to a third party collection agency unless the account has been approved for payment arrangements.

CUSTOMER SERVICE: If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (719) 477-0755. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a $25.00 service charge on all returned checks.

I acknowledge full financial responsibility for services provided to me. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and coinsurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center, and/or Briargate Endoscopy Center.

______________________	______________________	__________
Patient Signature	Witness Signature	Date

PIKES PEAK ENDOSCOPY CENTER

GACS Gastroenterology Associates of Colorado Springs

BRIARGATE ENDOSCOPY CENTER

OSMOPREP BOWEL PREPARATION INSTRUCTIONS

ONE WEEK BEFORE THE PROCEDURE:

- Discontinue iron supplements and aspirin, Aleve, Motrin, Advil, or any other anti-inflammatory medications. You may take Tylenol and/or a multivitamin with iron.
- You **must** speak with your primary care physician or a specialist before your scheduled colonoscopy if you are taking **Coumadin, Plavix, Ticlid, or any other Blood Thinners.** You may need to stop these medications a week prior to your procedure.
- **DO NOT TAKE THIS PRODUCT** If you have **congestive heart failure,** or **kidney disease** please call our office at (719)632-7101 for special instructions.
- It is important to continue to take all other prescribed medications. On the day of the procedure, you may take your prescribed medications with a small sip of water up to two hours before your procedure.
- Fill prescription for **OsmoPrep**

THE DAY BEFORE THE PROCEDURE

- **7:00AM**—Start the "Clear Liquids Diet" (**listed on the next page**) and continue the entire day. Do **NOT** eat solid foods or drink thick liquids all day.

Patients should drink plenty of clear liquids (at least 2 liters) throughout the day to achieve the best prep results!

- 5:00 PM THE DAY BEFORE THE PROCEDURE:Take 4 **OsmoPrep** tablets every 15 minutes with at least 8 ounces of Clear liquid until all 20 tablets have been consumed. Remain close to toilet facilities.

******IT IS VERY IMPORTANT TO DRINK THE FULL GLASS OF LIQUID WITH EACH DOSE******

THE DAY OF THE PROCEDURE

- **4 HOURS BEFORE PROCEDURE**
  Take 4 **OsmoPrep** Tablets every 15 minutes with at least 8 ounces of Clear liquid, until the remaining 12 tablets have been consumed.

THE DAY OF THE EXAM

- **Continue to drink clear liquids until 2 hours prior to your procedure. You MUST stop drinking 2 hours prior to your procedure.**
- **Note**: Individual responses to laxatives do vary. This prep may cause multiple bowel movements. It often works within 30 minutes but may take as long as 3 hours. Please remain within easy reach of toilet facilities.
- Some patients find it helpful to use Desitin or A&D ointment, and use baby wipes or personal cleansing cloths (instead of toilet paper) to avoid irritation from frequent wiping.

PREPARING FOR YOUR COLONOSCOPY

CLEAR LIQUID DIET

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed. NO RED, BLUE, OR PURPLE LIQUIDS SHOULD BE CONSUMED!

FOOD GROUP	FOODS ALLOWED	FOODS TO AVOID
Milk & beverages	Tea (decaffeinated or regular), carbonated beverages, fruit flavored drinks	Milk, milk drinks
Meats & meat substitutes	None	All
Vegetables	None	All
Fruit & fruit juices	Strained fruit juices: apple, white grape, lemonade, pulp free orange juice	Fruit juices with unstrained fruit
Grains & starches	None	All
Soups	Clear broth, consommé	All others
Desserts	Clear flavored gelatin, popsicles	All others
Fats	None	All
Miscellaneous	Sugar, honey, syrup, clear hard candy	All others

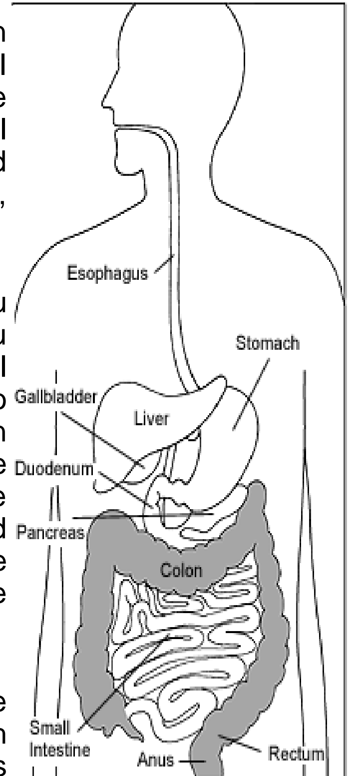
You may drink vanilla or chocolate Boost/Ensure the day before your procedure until your prep is started if extra caloric intake is needed.

SAMPLE DIET

BREAKFAST	LUNCH	DINNER
White grape juice	Apple Juice	Lemonade
Clear broth	Clear broth	Clear broth
Jell-O®	Jell-O®	Jell-O®
Tea/Coffee	Tea/Coffee	Tea/Coffee

Colonoscopy

Colonoscopy: Colonoscopy (koh-luh-NAH-skuh-pee) lets the physician look inside your entire large intestine, from the lowest part, the rectum, all the way up through the colon to the lower end of the small intestine. The procedure is used to diagnose the causes of unexplained changes in bowel habits. It is also used to look for early signs of cancer in the colon and rectum. Colonoscopy enables the physician to see inflamed tissue, abnormal growths, ulcers, bleeding, and muscle spasms.



For the procedure, you will lie on your left side on the examining table. You will probably be given pain medication and a mild sedative to keep you comfortable and to help you relax during the exam. The physician will insert a long, flexible, lighted tube into your rectum and slowly guide it into your colon. The tube is called a colonoscope. The scope transmits an image of the inside of the colon, so the physician can carefully examine the lining of the colon. The scope bends, by turning dials on the handset, the physician can move it around the curves of your colon. You may be asked to change position occasionally to help the physician move the scope. The scope also blows air into your colon, which inflates the colon and helps the physician see better.

If anything unusual is in your colon, like a polyp or inflamed tissue, the physician can remove a piece of it using tiny instruments passed through the scope. That tissue (biopsy) is then sent to a lab for testing. If there is bleeding in the colon, the physician can pass a laser, heater probe, or electrical probe, or inject special medicines, through the scope and use it to stop the bleeding. Bleeding and puncture of the colon are possible complications of a colonoscopy. However, such complications are uncommon.

The procedure can take up to 30 minutes and possibly longer if there are abnormal growths, inflamed tissue, ulcers, or bleeding. The sedative and pain medicine should keep you from feeling much discomfort during the exam. You will remain in recovery for a period of time until some of the sedative wears off. The sedative can cause you not to retain the discharge instructions provided by the discharge nurse, we recommend you have someone in your room with you to receive those instructions at the time of discharge so they can go over them again with you when you get home.

Preparation: Your colon must be completely empty for the colonoscopy to be thorough and safe. You have been provided instructions you should **read <u>1 WEEK</u>** prior to your procedure as there are special directions that may require you to stop certain medications (with your doctor's approval) one week before and a special diet you must start the day before your procedure. **Also, you must have someone come with you to stay during your procedure and drive you home afterward—you will not be allowed to drive because of the sedatives.**

1699 Medical Center Pt
Colo Spgs, CO 80907
(719)632-7101
www.GACSonline.com

1699 Medical Center Pt
Colo Spgs, CO 80907

4110 Briargate Pkwy
Suite 100
Colo Spgs, CO 80920

DIABETIC INSTRUCTIONS

INSULIN DEPENDENT

- THE MORNING BEFORE YOUR SCHEDULED TEST: take your normal AM dose of insulin.
- IF YOU TAKE AN AFTERNOON DOSE: Take ½ of your normal dose the afternoon before your test.
- THE MORNING OF YOUR TEST: Take ½ of your normal AM dose.
- DO FINGER STICKS AS NEEDED
- BRING YOUR INSULIN WITH YOU THE DAY OF YOUR PROCEDURE

MEDICATIONS

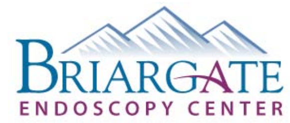
- THE MORNING BEFORE YOUR SCHEDULED TEST: Take your normal dose of pills.
- DO NOT TAKE ANY MORE PILLS UNTIL AFTER YOUR PROCEDURE IS DONE.
- IF YOU TAKE INSULIN AND PILLS PLEASE FOLLOW ALL OF THE ABOVE INSTRUCTIONS.

DIET DEPENDENT

- FOLLOW PREP INSTRUCTIONS AS GIVEN

YOUR NURSE WILL DO A FINGER-STICK WHEN YOU ARRIVE FOR YOUR PROCEDURE.

IF YOU HAVE ANY QUESTIONS PLEASE CALL 632-7101 AND SPEAK TO A MEDICAL ASSISTANT.



PATIENT INFORMATION SHEET

Patient Name:____SSN#_____________

Address:____
STREET CITY STATE ZIPCODE

Date of Birth:________________ **Gender**(please circle): M F **Status:** Married Single Divorced Widowed

Please check the box if you would prefer us **NOT** to contact you at the below numbers/address

☐Home Phone # : ______________________

☐Work Phone # : ______________________

☐Cell Phone # : ______________________ ☐**Email Address**: ______________________________

Emergency Contact (Name/Telephone #):____

Primary Care Physician (First/Last Name):____

Referring Physician (First/Last Name):____

I authorize the physician or anyone acting on his/her behalf to leave pertinent messages for me regarding my medical condition on my answering machine and/or voice mail.

(Please circle one) Yes No

Financially Responsible Party *(If Different From Patient)*

Last Name:______________________________ First Name:____________________________ MI:________

Street Address:____City:_________________ State:______

Home Phone:___________________________Work Phone:__________________ SS#_________________

Date of Birth: Relationship to Patient: Gender: M F

Insurance Information *(Must be completely Filled Out)*

Primary **Insurance Co Name:**	**Secondary** **Insurance Co Name:**
Insurance Co Address:	Insurance Co Address:
Patient's Insurance Policy #:	Patient's Insurance Policy #:
Patient's Group #:	Patient's Group #:
Insured's Name:	**Insured's Name:**
Insured's SS#:	**Insured's SS#:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Insured's Employer Name:	Insured's Employer Name:
Insured's Employer Phone #:	Insured's Employer Phone #:
Patient's Relationship to Insured:	Patient's Relationship to Insured:

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I hereby authorize payment directly to the physician/facility for all insurance benefits otherwise payable to me.

Signature:____ Today's Date:______________________

PIKES PEAK ENDOSCOPY CENTER

GACS Gastroenterology Associates of Colorado Springs

BRIARGATE ENDOSCOPY CENTER

AUTHORIZATION FOR COLONOSCOPY

At Pikes Peak Endoscopy and Surgery Center or Briargate Endoscopy Center

1. **PROCEDURE AND ALTERNATIVES**:
I, ________________________________, (patient or guardian) authorize Dr. ________________________________ to perform the procedure: **Colonoscopy** -Examination of the lining of the colon using a flexible video scope and if necessary remove polyps and/or small pieces of tissue (biopsies) for diagnosis.

   I understand the reason for the procedure is:____
   Alternatives include: Barium enema, Surgery, CT Colonography____

2. **RISKS:** This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include but are not limited to: infection, bleeding, abdominal pain, perforation of the intestines, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These risks can be serious and may require surgery or possible be fatal. Estimated perforation rate is 1:2,000-5,000 which usually requires surgery.

3. **ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize him to perform such treatment, as he deems necessary.

4. **ANESTHESIA**: For procedures requiring IV Conscious Sedation or General Anesthesia: My physician may elect to have me receive IV Conscious Sedation (medication given to reduce pain and/or anxiety during the procedure), or General Anesthesia (medicine given to produce unconsciousness), which would be administered by a qualified individual under the direct supervision of my physician or a board eligible/certified Anesthesiologist. Either IV Conscious Sedation or General Anesthesia may carry risks, including but not limited to, dental injuries, pneumonia, heart attack or other adverse reactions including death.

5. **LIMITATIONS OF COLONOSCOPY:** Colonoscopy is currently the best test available to detect and treat colon polyps, as well as diagnose colon cancer. However, no medical test will detect 100% of polyps and cancer. This is due to technical factors, such as the inability to see areas of the colon because of retained stool or sharp turns in the colon. Frequency of colonoscopy to screen colon polyps and cancer is based on national expert panels recommendations. However, a very small number of colon cancers (less than 1% of cases) can occur at earlier intervals despite optimal medical care. Because of this, the person undergoing colonscopy should be aware of the limitations of colonoscopy and should maintain a heightened alertness of any continuing or ongoing symptoms, and report them to their physician promptly.

6. I understand that no guarantee or assurance has been made as to the results for the procedure and that it *may not cure the condition.*

7. **PATIENT'S CONSENT:** I have read and fully understand this consent form, and understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words in this consent form.

I consent to any endoscopic photographing, as determined by my attending physician, for medical purposes.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSCIAN BEFORE SIGNING THIS CONSENT FORM.

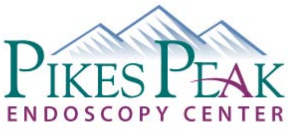
DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

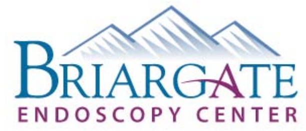
____ ________________________________ ____________________
Signature – Patient/Responsible Party Date Time

____
Signature – Witness

8. **PHYSICIAN DECLARATION:** I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

____
Signature – Physician Date





PATIENT CONSENT TO BE CONTACTED

National Endoscopic Database
Davis Lieberman, MD
Cynthia Morris, Ph.D., MPH

And

Gastroenterology Associates of Colorado Springs, LLP
Pikes Peak Endoscopy, LLC
Briargate Endoscopy Center
1699 Medical Center Point
4110 Briargate Parkway, Suite 100
Colorado Springs, CO

Richard Folan, MD
Primary Investigator

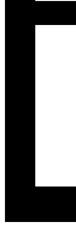
Pikes Peak Endoscopy Center and Briargate Endoscopy Center is a participating research site for the Clinical Outcomes Research Initiative (www.cori.org) and the National Endoscopic Database. The physicians of Gastroenterology Associates of Colorado Springs ask that you consider providing consent for the National Endoscopic Database to contact you in the future if your findings during your procedure make you eligible to participate in one of our research studies. This research is voluntary on your part. We receive no compensation for our participation in these studies, which is motivated by our commitment to furthering the understanding of and improving the diagnosis and treatment of gastro-intestinal diseases.

I consent to have an investigator affiliated with the National Endoscopic Database call me to discuss my participation in future research studies related to the examination I will undergo on _________________. I know that I will be called only if I qualify for a research study. I understand that I may refuse to participate in any of these research projects when they are explained to me. I also understand that I can change my mind in the future and take back (rescind) this consent to be contacted by an investigator. If I decline to have an investigator call me, this will not affect my medical care at this clinic in any way. The research is funded by the National Institutes of Health.

____ ____________________
Signature

____
Printed Name

______________________________ ______________________________ AM/ PM
Date Time



Statement of Patient Bill of Rights

BELIEVING IT IS ESSENTIAL THAT PATIENTS ARE RESPECTED AND SUPPORTED

In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of **Pikes Peak Endoscopy Center and Briargate Endoscopy Center**.

Patients have the Right :

To receive services without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor.

To be provided reasonable physical access.

To be provided a secure environment for self and property.

To be provided with appropriate privacy.

To be treated with respect, consideration and dignity.

To expect that all disclosures and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.

To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.

To be given opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.

To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved , and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy. The patient has the right to know the name of the person responsible for the procedures and/or treatment.

To be informed, when appropriate, of treatment policy for an emancipated minor not accompanied by an adult.

To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.

To be informed as to:

- Expected conduct and responsibilities as a patient
- Services available from the facility
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Right to refuse participation in investigational studies or clinical trials
- Methods for expressing grievance and suggestions to the facility
- Disclosure of ownership
- Procedure for reporting public health concerns to the appropriate authorities

To be informed of their rights to change primary or specialty physicians if other qualified physicians are available.

To be free from all forms of abuse or harassment.

To file a grievance against the center by contacting the administrator by mail or phone. If the outcome is not satisfactory a patient can contact the state licensing board through their web site http://www.dora.state.co.us/medical

To exercise his or her rights without being subjected to discrimination or reprisal

PIKES PEAK ENDOSCOPY CENTER

1699 Medical Center Point
Colorado Springs, CO 80907
Phone: (719) 632-7101

www. GACSonline.com

BRIARGATE ENDOSCOPY CENTER

4110 Briargate Prkwy Ste 100
Colorado Springs, CO 80920
Phone: (719) 632-7101

www. GACSonline.com

The Patient Has the Responsibility:

To provide, to the best of the patient's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, existence of advance directives, medications and other information relating to health status.

To follow the treatment plan recommended by the practitioner primarily responsible for the patient's care and other personnel authorized by PPESC or BEC to so instruct the patient.

To accept the consequences of his/her own actions when refusing treatment or not following the practitioners' instructions.

To assure that the financial obligations for health care rendered are fulfilled as promptly as possible.

To follow rules and regulations affecting care and conduct pertaining to the procedures performed.

To be considerate of the rights of other patients and facility personnel and to assist in the control of noise.

To be respectful of the property of other persons and of the facility.

Pikes Peak Endoscopy Center

1699 Medical Center Point
Colorado Springs, CO 80907
Phone: (719) 632-7101
Fax: (719) 632-4468
www.GACSonline.com

Briargate Endoscopy Center

4110 Briargate Parkway, Ste. 100
Colorado Springs, CO 80920
Phone: (719) 632-7101
Fax: (719) 632-4468
www.GACSonline.com

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW GASTROENTEROLOGY ASSOCIATES OF COLORADO SPRINGS, PIKES PEAK ENDOSCOPY AND SURGERY CENTER AND BRIARGATE ENDOSCOPY CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center or received by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may determine that you require the services of a specialist. In referring you to another doctor, Gastroenterology Associates of Colorado Springs/ Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits of health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of service to be provided to you.

For example, Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use your diagnosis, treatment, and outcome information to measure the quality of the services we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designed in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- **As permitted or required by law**. In certain circumstances, we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- **For public health activities**. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request for that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

  We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees,

or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- **For health oversight activities**. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state or governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable disease.

- **Judicial and Administrative Proceedings**. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- **For activities related to death**. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- **For research**. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- **To avoid a serious threat to health or safety.** We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- **For workers' compensation.** We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center, please contact the Privacy Officer at the following:

Privacy Officer
Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center
1699 Medical Center Point
Colorado Springs, CO 80907
Telephone: (719) 632-7101 Fax: (719) 632-4468

It is the policy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

[1] This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_______________________________ acknowledge that I have received a copy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and/or Briargate Endoscopy Center's Notice of Privacy Practices. This Notice describes how Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and Briargate Endoscopy Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____________________________________ ___________
Signature of Patient or Representative **Date**

____
Relationship to Patient

PIKES PEAK
ENDOSCOPY CENTER

BRIARGATE
ENDOSCOPY CENTER

NOTICE OF POLICY REGARDING ADVANCED DIRECTIVES

Pikes Peak Endoscopy and Surgery Center, LLC and Briargate Endoscopy Center, L.L.C. require the following notice be signed by each patient prior to the scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives. Advance directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are witnessed prior to serious illness or injury.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life threatening situations, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, **this facility (PPESC/BEC) is notifying you it will NOT honor previously signed advanced directives for any patient, however, if you have executed an advance directive in the past you may bring it with you and we will scan it into our system.**

If you have questions, please call (719) 632-7101 and follow the appropriate prompts to speak to a scheduler.

I have read and fully understand the information presented in this release form.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

____________________________________ ______________________________
Signature – Patient Date

____________________________________ ______________________________
Signature – Witness to Patient Signature Date

If patient is unable to sign or is a minor, please sign below:

____________________________________ ______________________________
Signature – Relative or Legal Guardian Date

____________________________________ ______________________________
Signature – Witness to Relative/Guardian Signature Date

PPESC/BEC HEALTH QUESTIONNAIRE

Patient Name:____ Date:_______________________________
Primary Care Physician:_____________________________________ Referring Dr:_________________________
List all physicians you would like a report to go to: ____
Reason for the procedure:____

Please check any symptoms that are of concern:

- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Weight Loss
- ☐ Swallowing difficulty
- ☐ Heartburn
- ☐ Blood in Stools/Rectal Bleeding

List all allergies/sensitivities to medications, tape, latex, foods, etc._________________________ ☐ None

PLEASE LIST ALL YOUR PREVIOUS SURGERIES

YEAR	SURGERY	COMMENTS

PLEASE ANSWER THE FOLLOWING QUESTIONS

☐ Family history of colon cancer? (whom)___________________
☐ Family history of colon polyps? (whom)___________________
☐ Personal history of cancer? ☐ Yes ☐ No
Primary site/type:______________________________
☐ Have you had colon polyps before? ☐ Yes ☐ No
☐ Have you had a positive TB test before? ☐ Yes ☐ No
☐ Hepatitis B / Hepatitis C / HIV? ☐ Yes ☐ No
* Do you smoke? Yes ☐ No ☐
How many years? _______ How much _________
* Could you be pregnant? Yes ☐ No ☐
* Diabetes ______________ Yes ☐ No ☐
* Do you have an implantable heart device?
i.e., defibrillator, pacemaker, etc.? Yes ☐ No ☐
* History of heart valve replacement? Yes ☐ No ☐
* Do you take blood thinners? Yes ☐ No ☐
What kind? _______________________ When did you stop? ___________________
* Do you take aspirin? Yes ☐ No ☐
When did you stop?_________________________________
* Do you have kidney disease? Yes ☐ No ☐
* Do you have sleep apnea or on a CPAP machine/Oxygen Yes ☐ No ☐
* Do you have an allergy to Demerol / Versed / Fentanyl? Yes ☐ No ☐

Do you have history of any of the following? (circle any that apply) Stroke / Ulcers / Anemia / Heart Attack / High or low blood pressure / Lung Disease (Asthma, COPD, Emphysema)

By signing below, I am agreeing that this information is accurate to the best of my knowledge. I also agree that I will not drive home if I am given any medications during this procedure.

_________________________________ _________________________________ __________________
Patient/Responsible Party Signature Nurse's Signature Date

____ __________________________
Physician Signature **Date**

Online Communications Informed Consent

For online communications with Gastroenterology Associates of Colorado Springs/Pikes Peak Endoscopy/Briargate Endoscopy

Instructions for Using Online Communications

You agree to take steps to keep your online communications to and from me confidential including:

- Do not store messages on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.
- Use screen savers or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third party access to the computer(s) upon which you store medical messages or other personal medical information.
- If you have or learn of any personal email addresses that I use, you will not use them for medical communications. Standard email lacks security and privacy features and may expose medical communications to employers or other unintended third parties.
- Withdrawal of this Informed Consent must be done by written online communications or in writing to my office.

Use good communications etiquette:

- Confirm that your name and other personal information in the message is correct.
- Review the message before sending it to make sure that it is clear and that all relevant information is included.
- Update your contact information on the network as soon as it changes including any changes to your regularly used email address. I do not use your standard email account for security reasons, but notifications are sent to your standard email address when a message has been sent to you and is waiting for you in your secure mailbox.

Charges for Using Online Communications

My office may charge for certain online communications. You will be informed in advance when/if these charges apply and you will be responsible for payment of these charges if you accept and use any fee-based service. You may choose to contact your insurance carrier to determine if they cover online communications.

Conditions of Using Online Communications

The following agreements and procedures relate to online communications:

- My office will print out a copy of all medically important online communications and include it in your medical record. This means that appropriate members of my staff will have access to these communications as part of our medical records keeping, treatment and billing.
- You should print or store (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.
- I will not forward online communications with you to third parties except as authorized or required by law.
- You agree to follow the procedures that I implement that will allow me to verify your identity in connection with online communications and you acknowledge that failure to comply with these procedures may terminate our online communications.
- Online communications will be used only for limited purposes. It cannot be used for emergencies or time sensitive matters. It should be used with caution. It should not be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.) If there is other information that you don’t want transmitted via online communications, you must tell me.
- I will make every attempt to respond within the timeframe I have designated. However, there may be times when this is not feasible, and you understand and agree to accept variations in response times and use other forms of communications with my office and me if online responses are not satisfactory to you. Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools.
- While I will take reasonable precautions to protect your information, I am not liable for improper disclosure of confidential information unless it was caused by my intentional misconduct.
- Follow-up is your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communication wasn.t received.
- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. I am not responsible for breaches of confidentiality caused by you or an independent third party.
- I will not engage in any illegal online communication, including illegally practicing medicine across state lines.

Access to Online Communications

The following pertains to access to and use of online communications:

- Online communication does not decrease or diminish any other ways in which you can communicate or see me. It is an additional option and not a replacement. You are encouraged to contact my office via telephone, mail or in person, as always, if you have any questions or needs.
- I alone will decide which medical topics are appropriate for online communications and with whom I communicate online.
- I may stop providing online communications with you or change my online services provided at any time without prior notification to you.

Risks of Using Online Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very
important to understand. It is very important that you consider these risks each time you plan to communicate with me, and communicate in such a fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:

- Online communication may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. A dishonest person could attempt to impersonate you to try to get your medical records.
- It is harder to get rid of an online communication. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
- Online communication is not private simply because it relates to your own medical information. I use a secure network to avoid using standard email or email systems provided by employers. Employers and online services have a right to inspect and keep online communications transmitted through their system.
- Online communications are also admissible as evidence in court.
- Online communications may disrupt or damage your computer if a computer virus is attached.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers.

Patient name: ____

Patient email address: ____

Patient signature: ____

Date: ____

PIKES PEAK ENDOSCOPY CENTER

BRIARGATE ENDOSCOPY CENTER

Pikes Peak Endoscopy Center
Briargate Endoscopy Center

1699 Medical Center Point, Colorado Springs, CO 80907
4110 Briargate Parkway Colorado Springs, CO 80920
Phone: (719) 632-7101 Fax: (719) 632-4468
www.GACSonline.com

PIKES PEAK ENDOSCOPY CENTER 1699 MEDICAL CENTER POINT

BRIARGATE ENDOSCOPY CENTER 4110 BRIARGATE PARKWAY, SUITE 100

THESE ARE CASH PAY PRICES. IF YOU HAVE INSURANCE THE PRICES MAY VARY. COPAYS MAY OR MAY NOT APPLY.

	NuLytely (Liquid)	OsmoPrep* (Pills)** (see critical warning below)	
Kmart	$33.67	$69.97	
King Soopers 9225 N. Union	$35.09	$73.00	Discount Card available at Pharmacy
Safeway	$39.99	$77.49	
Medicine Shoppe 2439 N. Union	$34.95	$66.95	Dulcolax pills provided free
Walgreens	$42.99	$74.29	
Walmart	$28.36	$70.68	

***Osmoprep is <u>NOT RECOMMENDED</u> in the following patients as irreversible injury may occur:**

- Patients with kidney disease, kidney failure or any reduction in kidney function
- Patients on medicines that can affect kidney function
- Patients with Congestive Heart Failure (CHF)
- Patients over age 65 years

****If you have difficulty swallowing pills, you may want to do a liquid prep.

Patient Medication Form

*Please list **ALL** medications you are taking to include any over-the-counter (OTC) medications*

Medications	**Dose/frequency**	**DO NOT FILL OUT BEYOND THIS POINT**	***Office use only***	
			Resume	**Hold**

Patient Information:
(Apply pt label here)

Follow up Appt ________________
☐ Resume normal diet
☐ Clear Liquids
☐ Other ________________

Comments/new medication instructions___________________________

____

☐ Resume all pre-procedure medications
☐ Patient Stable for Discharge

Doctor's Signature/Date____