



GATEWAY GASTROENTEROLOGY

St. Luke's Outpatient Center
121 St. Luke's Center Drive, Suite 106
Chesterfield, MO 63017
Office: (314) 432-5900
www.gatewaygi.com

David D. Benage, M.D.
Jeffrey T. Kreikemeier, M.D.
Loren H. Marshall, M.D.
Jeffrey E. Mathews, M.D.
Brian C. McMorrow, M.D.
Richard T. Riegel, M.D.
Andrew Y. Su, M.D.
Fred H. Williams, M.D.
Cheri M. Carmody, A.N.P.

COLONOSCOPY PREPARATION INSTRUCTIONS

Please read this information as soon as you receive it!!

**If you have any questions about these instructions or to make a change to your appointment, Please call:
(314) 432-5900 (Office) Press Option 2
(314) 388-6519 (Exchange)**

Your procedure is scheduled for _____ at _____

Your procedure is scheduled at **Gateway Endoscopy Center**. Please arrive **1 hour** prior to your scheduled appointment time.

Gateway Endoscopy Center is located in the Walker Medical Building at 12855 North 40 Drive, Suite 150, St. Louis, MO 63141 in the **South Tower**.

For patients coming from the east (traveling west on U.S. 40):

- ▶ Exit U.S. 40 at Mason Road (Exit 24)
- ▶ Immediately upon exiting onto Mason Road, make a quick right onto N. 40 Drive (the frontage road).
- ▶ Go about 1/2 mile to the Walker Building and turn left into the parking lot. (The building is located between Lutheran Hour Ministries and CBC (Christian Brothers) High School.
- ▶ Enter the doors for the **South Tower**. Take the stairs or the elevator to the first floor. Suite 150 is on the right.

For patients coming from the west (traveling east on U.S. 40):

- ▶ Exit U.S. 40 at Mason Road (Exit 24)
- ▶ Go to the stoplight at Mason Road and make a left.
- ▶ Go across the bridge over U.S. 40 and immediately turn right on N. 40 Drive (the frontage road).
- ▶ Go about 1/2 mile to the Walker Building and turn left into the parking lot. (The building is located between Lutheran Hour Ministries and CBC (Christian Brothers) High School.
- ▶ Enter the doors for the **South Tower**. Take the stairs or the elevator to the first floor. Suite 150 is on the right.

If you cannot keep your scheduled appointment, please notify us at least **2 business days** before your scheduled time.

Please review the “special circumstances” section of this document carefully to see if you require special instructions or modifications.

BOWEL PREPARATION:

Necessary items:

- ▶ One 8.3 oz bottle of Miralax (Polyethylene glycol powder). This is available over the counter
- ▶ Four 5 mg. Dulcolax pills. Dulcolax is available over the counter. Please purchase the laxative formula not the stool softener.
- ▶ Two 32oz. bottles of Gatorade, any flavor.

Two days prior:

- ▶ Eat as you would normally, or eat less than normal. Overindulging on food will make it harder to get the colon cleaned out adequately.

The day prior to your procedure:

- ▶ Consume only clear liquids on this day. **No solid food!** Examples of clear liquids include: water, any kind of soda, Gatorade, coffee, Popsicles, tea, Jell-O, broth, bouillon, and fruit juices that you can see through (apple and grape are OK, orange and tomato are not). You may have all the clear liquids you desire throughout this day and evening. No alcohol allowed. Please note that if you consume red Jell-O, Gatorade or popsicles with your bowel prep that your stool may be red in color. This is nothing to be alarmed about.
- ▶ Mix half of the 8.3 oz bottle of Miralax in each 32 oz. bottle of Gatorade until dissolved and keep cold in the refrigerator.
- ▶ Begin bowel preparation between 12 and 4pm depending on whether you plan to work full day prior to the procedure. (Please note that starting the bowel preparation later in the day may lead to a more restless night because of ongoing bowel movements.)
- ▶ For those choosing to start the bowel preparation at **noon**:
 - take four 5 mg. Dulcolax pills with water and continue clear liquids.
 - at 12:30pm, start drinking the first bottle of Miralax/Gatorade solution. Drink 1 glass every 15-20 minutes until the first bottle is gone.
 - Between 3-4pm, begin drinking the second Miralax/Gatorade solution and finish all 32 oz.
- ▶ For those choosing to start the bowel preparation at **4pm**:
 - take the four 5 mg. Dulcolax pills with water and continue clear liquids
 - at 4:30 pm start drinking the first bottle of Miralax/Gatorade solution. Drink 1 glass every 15-20 minutes until the first bottle is gone
 - Between 7-8 pm, begin drinking the second Miralax/Gatorade solution and finish all 32 oz.
- ▶ **DO NOT CONSUME ANYTHING AFTER MIDNIGHT EXCEPT MEDICATIONS UNTIL AFTER YOUR PROCEDURE.**
- ▶ You may take your usual medications with sips of water **both the day before and as early as possible on the day of the procedure.**

- ▶ If your bottom is sore, try an ointment such as A&D ointment, Preparation H, or Vaseline to the anal area as needed.

The day of the procedure:

- ▶ Arrive at Gateway Endoscopy Center **1 hour** prior to your scheduled appointment time.
- ▶ **You will need someone to drive you to and from the Endoscopy Center AND wait in the waiting room until the procedure is done. The procedure can't be done unless you have a driver. You will be there for approximately 2 hours from the time you arrive.**
- ▶ We have enclosed a patient information form, a medical history form, medication list and a financial policy. **Please fill these out at home and bring them with you to your appointment along with your insurance cards and drivers license.** If you have any questions, the nurse will go over it with you at the time of your appointment.
- ▶ All Female Patients: If you are between the ages of 12-49, you will be required to give a urine specimen unless you have had a Hysterectomy or Tubal Ligation.

SPECIAL INSTRUCTIONS:

Patients with an automatic implantable defibrillator and /or pacemaker: Please call us at least five (5) days before the procedure for instructions.

Coumadin (warfarin): Call your primary care doctor or cardiologist and ask if you can safely stop the Coumadin four (4) days before the procedure. If your doctor tells you that you cannot stop the Coumadin, then please call us immediately to make us aware of this. We will then discuss with you the various options available.

Iron: Stop iron four (4) days before the procedure. Iron can make preparation difficult and result in a poorly cleaned colon

Antibiotics for procedures: Recent publications from both the American Heart Association and American Society for Gastrointestinal Endoscopy state that antibiotics are not necessary for routine endoscopic procedures.

Insulin: Call your primary care doctor at least five (5) days before the procedure and ask for instructions.

Plavix: (clopidogrel) and aspirin: It is not necessary to stop Plavix and aspirin prior to your procedure.

Herbal Medications: It is best to stop any herbal remedies five (5) days before the procedure as many of them can thin the blood and increase the risk of bleeding during the procedure.

ADDITIONAL INFORMATION:

Approximately 3 business days prior to your procedure, you will be receiving an automated phone call from our Phone Tree system reminding you of your appointment. Please listen to this entire message and press the appropriate number for your response regarding your appointment. If you are not at home, Phone Tree will leave a message on your answering machine. Unless you want to cancel or reschedule your appointment, it is not necessary to call the office to confirm. We will assume you are keeping your scheduled appointment unless we hear from you.

We also suggest that you contact your insurance to verify coverage for colonoscopy. Some insurance plans cover colonoscopy for colon cancer screening or routine/preventative care. Other plans only cover colonoscopy if you are having symptoms or they may say it's covered only if "medically necessary". There are many different insurance companies and each individual plan is different. Please let the physician know if your plan covers colonoscopy for colon cancer screening so we can code it properly.

You may visit our website (www.gatewaygi.com) for more detailed information regarding the physician you will be seeing and other services offered.

HOW DID YOU HEAR ABOUT OUR PRACTICE:

Primary Care M.D. OB/GYN Internet Friend/Family Advertisement Other _____

NAME: MR./MRS./MS.

STREET ADDRESS:

CITY: STATE: ZIP:

SSN: DOB:

HOME PHONE NUMBER: ALTERNATE NUMBER:

EMPLOYER: OCCUPATION:

MARITAL STATUS: SPOUSES NAME:

EMERGENCY CONTACT: RELATIONSHIP TO CONTACT:

THE FOLLOWING IS REQUIRED BY THE STATE OF MISSOURI:

Hispanic or Latino Neither Hispanic or Latino

RACE:

White Black or African American American Indian or Alaska Native Asian Native Hawaiian/Pacific Island
 Other Multi-Racial (two or more races) Choose Not to Answer

MEDICAL INSURANCE INFORMATION

Primary Insurance Company

Phone Number

Policy/Id#

Group#

Relationship to policy holder

Policy Holder DOB

Secondary Insurance Company

Phone Number

Policy/Id#

Group#

Relationship to policy holder

Policy Holder DOB

Responsible Party

NAME: MR./MRS./MS.

STREET ADDRESS:

CITY: STATE: ZIP:

SSN: DOB:

HOME PHONE NUMBER: ALTERNATE NUMBER:

EMPLOYER: OCCUPATION:

RESPONSIBLE PARTY/GUARANTOR'S SIGNATURE

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to Gateway Gastroenterology, Inc and Gateway Endoscopy Center for services rendered. I permit a copy of this authorization to be in place of the original. I understand that I am financially responsible to these providers of service for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

I have received a copy of Notice of Privacy Practices

SIGNATURE

DATE

SIGNATURE

DATE

GATEWAY ENDOSCOPY CENTER - MEDICATION RECONCILIATION FORM

Allergies (food, medication, latex, etc)
Name and Type of Reaction:

- List **all your medications** including eye drops, over-the-counter, and alternative medicines such as vitamins, herbals, and supplements.
- It is extremely important for your care and safety that you provide complete and accurate information.
- Please let your nurse know if you do not remember all of the medications that you take.

MEDICATION LIST

Medication Name	Dose	How often do you take it?	Why are you taking this medication?	Last Dose Taken

It is suggested that you provide a copy of this list to your Primary Care Provider.

Reviewed by RN: _____
Signature Date/Time

- No Changes to Medications
- Changes
- Patient education regarding medication changes

Medications Reconciled by RN: _____
Signature Date/Time

Gateway Endoscopy Center and its providers are not responsible for medications ordered by other organizations or providers.

PATIENT HISTORY FORM

Patient Name _____ Date of Birth: _____ Referred by _____
Driver _____ Driver's Phone Number _____

Married Divorced Single Separated Widowed
Retired Occupation _____ Number of Children _____

Medical History (Please Circle):

Rectal Bleeding	Heartburn	Difficulty Swallowing	Hiatal Hernia
Diverticulosis/Diverticulitis		Gas/Bloating	Constipation
Diarrhea	Gallbladder Problems	Pancreatitis	Loss of Appetite
Change in bowel movements		Nausea/Vomiting	Abdominal Pain
Crohn's	History of Ulcers	History of Polyps	History of Colon Cancer
Kidney Problems	Indigestion	Recent Weight Change	Sore Throat
Liver Disease	Shortness of Breath	Asthma	High Blood Pressure
Seizures	Stroke	Migraines	Ulcerative Colitis
Diabetes	Heart Disease/Stents	CHF	Anemia
Dentures	Hearing Loss	COPD	Sleep Apnea
Glasses/Contacts			
Other _____			

Surgeries _____

Smoking Y/N Pack/Years _____ Year Quit _____
Alcohol Y/N Drinks/Day _____ Year Quit _____

Family History of Colon Cancer? Y/N If yes, who? _____
Family History of Polyps? Y/N If yes, who? _____

Last Colonoscopy - Year? _____ Last Upper Endoscopy - Year? _____

Do you have pain now or have you had pain the last several weeks? Y/N

If yes, rate the pain on a scale of 1-10, with 10 being the worst _____

Describe the pain. Where is it located? What aggravates it? What alleviates it? How long does it last?

Prior problems with anesthesia? Y/N

If yes, please describe _____

Reason for Procedure: _____

PATIENT SIGNATURE

NURSE SIGNATURE INDICATING REVIEW

FINANCIAL DISCLOSURE

Dear Patient:

We would like to take this opportunity to welcome you to our facility, and let you know that we are committed to providing you with the best possible care. Please take a few minutes to read this important information regarding our financial policies. We will gladly discuss your proposed treatment and answer any questions you have relating to your charges.

For billing purposes, there are separate service components for which you will be billed separately:

1. **Physician's Professional Charge:** Your physician will bill this charge separately to you. This billing is for the physicians's professional services that are provided during your procedure.
2. **Facility Charge:** We will also bill a facility fee for the use of the Gateway Endoscopy Center in which your procedure is being performed. If the procedure requires additional services, the billing will be increased depending on the added equipment.
3. **Laboratory and Pathology Charge:** If you have a biopsy taken and/or blood drawn, you will receive a bill from the laboratory that processes your biopsy and/or blood work.
4. **Anesthesia Charge:** If your procedure utilizes the services of the anesthesia provider, this professional charge will be billed separately to you. This billing is for the anesthesia provider's professional services that are provided during your procedure.

Payments made to the center on the day of service are credited towards the facility charge only.

If you have insurance, we will file a claim for you. Please understand that your insurance is a contract between you and your insurance company and that complete payment to us is ultimately your responsibility. Under certain circumstances, some insurance carriers may not always cover or may deny payments for services provided. If, at the end of thirty (30) working days, your insurance has not remitted payment to us, payment will be due from you in full.

If you belong to an insurance plan we will follow the guidelines set forth in those plans. Please be sure to bring a referral form with you for your appointment if applicable. Services cannot be rendered if proper authorization hasn't been given. We do participate in Medicare.

If you do not have insurance, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. To assist you, we accept checks, MasterCard, Visa and Discover.

We recognize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collection should we deem it necessary.

If you have a question about the above information or any uncertainty regarding insurance coverage, don't hesitate to ask us. We are here to help you.

I understand the above charges, which have been discussed with me. Furthermore, I understand that I am responsible for my balance in full and do hereby agree to pay any balance unpaid by my insurance company.

SIGNED: _____ DATE: _____

WITNESSED: _____

PATIENT RIGHTS

Every patient has the right to be treated fairly, with respect and as an individual.

Patients are treated with respect, consideration, and dignity.

Patients are provided appropriate privacy.

Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse of their release.

Patients are informed of their right to formulate an advanced directive, at the time the procedure is scheduled, and to appoint a designated representative to make healthcare decisions on their behalf to the extent permitted by law. This facility does not honor advance directives and the patient has the right to schedule their procedure at another facility.

Patients are 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 or to a legally authorized person.

Patients are given the opportunity to participate in decisions involving their healthcare, except when such participation is contraindicated for medical reasons.

Patients are provided information about treatment alternatives and will be advised of the advantages and disadvantages of each.

Patients have the right to refuse to participate in experimental research.

Patients have the right to know in advance the type and expected cost of treatment.

Patients have the right to know that the physician that refers you to the Endoscopy Center may have ownership interest in this facility. You are free to choose another facility in which to receive services. You were informed both in writing and verbally prior to the date of service.

Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.

Patients and families have the right to express grievances and suggestions to the organization. Every effort will be made to follow up on all grievances and suggestions. Patient care and satisfaction are very important to our entire staff.

PATIENT RESPONSIBILITY AND CONDUCT

To provide healthcare providers with information about any past illness, hospitalizations, medications and other health matters.

To ask questions if they do not understand instructions or explanations given by the healthcare providers and/or staff.

To keep appointments as scheduled and to telephone the office in case of a cancellation.

To follow healthcare providers instructions and plan of treatment.

To make payments for services rendered if a balance remains after insurance pays.

To discuss consequences of refusing treatment or not adhering to plan of treatment or leaving Against Medical Advice (AMA) with their physician.

To refuse to participate in experimental research, if that is their desire.

To refuse to allow care from a student or trainee, if that is their desire.

NOTICE

Anyone having concerns about the quality of care provided in this organization may report these concerns to the organization's management, the Missouri Department of Health and Senior Services, the Joint Commission or Medicare. A quality Incident Report Form is available upon request. You may choose to report anonymously or provide your name and contact information.

The Joint Commission

JCAHO

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

(800) 994-6610

Missouri Department of Health and Senior Services

Contact the Health Facilities Regulation Unit

P.O. Box 570

Jefferson City, MO 65102

(573) 751-6303

dhcc.mo.gov

You may also fill out a concern form online at

<http://www.dhss.mo.gov/AskUs.html>

Medicare

Website for the office of the Medicare Beneficiary Ombudsman

<http://www.cms.hhs.gov/ombudsman/resources.asp>

(800) 633-4227