GATEWAY GASTROENTEROLOGY INC
OFFICE: (314) 529-4900
FAX: (314) 434-2679
WWW.GATEWAYGI.COM

ENDOSCOPY PREPARATION INSTRUCTIONS

Your procedure is scheduled for _____at _____

Gateway Endoscopy Center
12855 North Forty Drive
South Tower, Suite 150
St. Louis, MO 63141
(314) 336-1130

Please arrive **1 hour** prior to your scheduled appointment time.

For patients coming from the east (traveling west on US 40):

- Exit US 40 at Mason Road (Exit 24).
- Immediately upon exiting onto Mason Road, make a quick right onto North Forty Drive.
- The Walker Medical Building will be approximately ½ mile on the left. (The building is located between Lutheran Hour Ministries and CBC High School.)
- Enter the South Tower, Suite 150 is on the first floor.

For patients coming from the west (traveling east on US 40):

- Exit US 40 at Mason Road (Exit 24).
- Go to the stoplight at Mason Road and turn left.
- Go across the bridge over US 40 and immediately turn right on North Forty Drive.
- The Walker Medical Building will be approximately ½ mile on the left. (The building is located between Lutheran Hour Ministries and CBC High School.)
- Enter the South Tower, Suite 150 is on the first floor.

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.

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PREPARATION:

- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT**.
- You may take your usual medications with sips of water as early as possible on the day of your procedure

The day of the procedure:

- If you are a smoker, please do not smoke the day of your procedure. This includes e-cigarettes, cigars, cigarettes, pipe, and marijuana.
- You may take your usual medications with sips of water as early as possible the day of the procedure.
- Arrive at Gateway Endoscopy Center 1 hour prior to your scheduled procedure time.
- **SOMEONE WILL NEED TO DRIVE YOU TO AND FROM THE CENTER**.
  - You and your driver can plan to be at the center approximately 2 hours total.
  - You will not be able to drive or drink alcohol the rest of the day.
- 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
- Please bring with you:
  - ☐ Insurance cards
  - ☐ Picture ID
  - ☐ Completed patient information form
  - ☐ Completed patient history form
  - ☐ Completed medication reconciliation form
  - ☐ Financial disclosure and agreement

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SPECIAL INSTRUCTIONS

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

If you have had a cardiac stent placed in the last 12 months or if you are taking an anti-platelet medication with aspirin, please contact our office at 314-529-4900 to discuss.

Coumadin, Jantoven (warfarin), Arixtra (fondaparinux): Call your prescribing physician and ask if you can safely stop this medication **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.

If you take **Eliquis (apixaban), Fragmin (dalteparin), Iprivask (desirudin), Lovenox (enoxaparin) Pradaxa (dabigatran) or Xarelto (rivaroxaban):** Call your prescribing physician and ask if you can safely stop these medications **2 days** before your procedure. If your doctor tells you that you cannot stop these medications, please call us immediately to make us aware of this. We will then discuss with you the various options available.

Plavix (clopidogrel), Brilinta (ticagrelor), or Effient (prasugrel): If you are taking any of these medications **WITH Aspirin**, please call our office at 314-529-4900 to discuss. If you are taking any of these 3 medications **without Aspirin**, it is not necessary to stop them prior to your procedure.

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 publication 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 prescribing physician at least five (5) days before the procedure and ask for instructions.

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 risk of bleeding during the procedure.

Additional Information:
Approximately 3 business days prior to your procedure, you will be receiving a phone call reminding you of your appointment. If you are not home, a message will be left on your answering machine/voicemail. 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.

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

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PATIENT PORTAL

Gateway Gastroenterology has a Patient Portal for you to access some of your information. This portal shows any upcoming or previous appointments and you can also securely communicate with our office for questions to the doctor, nurse practitioner or staff.

You will get access to the Patient Portal once we have obtained your email address and have entered it into our practice management system. You will receive an email once we have enabled you to continue the registration process.

The web address: **https://health.healow.com/gatewaygi**

Please bookmark or save this to your Favorites.

At this time the portal does not show your medications or any results.

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WELCOME

Dear Patient:

Welcome to Gateway Gastroenterology! We look forward to meeting you. We'd like to take this opportunity to tell you a little about our practice.

Gateway Gastroenterology is a group of eight board-certified gastroenterologists that was established in 1984. Our areas of expertise include the esophagus, stomach, small intestine, colon, liver, gallbladder, and pancreas. We offer a wide variety of gastroenterology services including inpatient and outpatient consultation as well as a broad range of endoscopic procedures including screening colonoscopy, upper endoscopy, testing for dietary intolerance, etc.

Our goal is to provide outstanding care in a timely, courteous, and professional manner. All of our physicians are committed to ongoing education and will make every effort to provide you with the most up to date and thorough care possible.

We will try hard to make your experience with us as hassle-free as possible. To this end, we will see you in a timely manner, return phone calls, and communicate with your other physicians.

Our practice includes Board Certified Nurse Practitioners who are specialized in gastroenterology and assist us in seeing patients in the office. Through their work, we are able to provide greater office time availability and flexibility. Our staff consists of friendly and knowledgeable people that are available to help with your scheduling, billing, and insurance needs.

We look forward to working with you.

Respectfully,

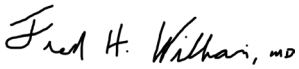

Jonathan C. Seccombe, M.D.


Jeffrey E. Matthews, M.D.


Andrew Y. Su, M.D.


Jeffrey T. Kreikemeier, M.D.


Brian C. McMorrow, M.D.


Fred H. Williams, M.D.


Richard T. Riegel, M.D.


Rajeev Ramgopal, M.D.


Cheri M. Carmody, A.N.P.


Kaitlin C. Doneff, A.G.N.P.

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HOW DID YOU HEAR ABOUT OUR PRACTICE?

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

Name: _____ Sex: Male / Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Email Address: _____

Home Phone Number: _____ Alt. Contact Number: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Referring Physician: _____

The following is **required** by the State of Missouri (select one): ☐ Hispanic or Latino ☐ Neither Hispanic nor Latino

RACE ☐ White ☐ Black or African American ☐ American Indian ☐ Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Island ☐ Other not listed ☐ Multi-Racial (two or more races) ☐ Choose not to answer

Language Spoken: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: _____

Policy/Id Number: _____ Group Number: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

Secondary Insurance Company: _____ Phone Number: _____

Policy/Id Number: _____ Group Number: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

POLICY HOLDER INFORMATION (IF OTHER THAN PATIENT)

Name: Mr/Mrs/Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Relationship to Patient: _____

Home Phone Number: _____ Alt. Contact Number: _____

Employer: _____ Occupation: _____

Responsible party/Guarantor's Signature: _____

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

By providing the information I agree that Gateway Gastroenterology, Inc. or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, leave a voice message on an answering device, send mail to my home address, or email notification regarding my care, our services, or my financial obligation. I hereby authorize the release of any medical information necessary to process my health insurance claims. I permit a copy of this authorization to be in place of the original. I have received a copy of Notice of Privacy Practices.

_____ _____

Signature Date

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GATEWAY ENDOSCOPY CENTER – MEDICATION RECONCILIATION FORM

Patient Name: _____ Date of Birth: _____

ALLERGIES (food, medications, latex, etc.)

Medication Name	Reaction	Medication Name	Reaction

MEDICATION LIST

- 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 Name	Dosage	Frequency (How Often)	Why are you taking this medication?	Last dose taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

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

OFFICE USE ONLY

Reviewed by RN _____ Date / Time: _____
Signature

☐ No changes to Medications; Resume home Medications

☐ Changes

New Medication Name	Dosage	Frequency	Purpose of Medication

☐ Patient education regarding medication changes

Medications Reconciled by RN _____ Date / Time: _____

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

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GATEWAY ENDOSCOPY CENTER - PATIENT HISTORY FORM

Name: _____ D.O.B.: _____ Referred By: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Advanced Directive Y / N

☐ Retired Occupation: _____ Number of Children: _____

Driver's Name: _____ Driver's Phone Number: _____

CURRENT SYMPTOMS

- ☐ Difficulty Swallowing
- ☐ Heartburn/Indigestion
- ☐ Sore Throat
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Gas/Bloating
- ☐ Abdominal Pain
- ☐ Recent Weight Change
- ☐ Change in Bowel Movements
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding

PERSONAL MEDICAL HISTORY

- ☐ GERD
- ☐ Barrett's Esophagus
- ☐ Schatzki's Ring
- ☐ Hiatal Hernia
- ☐ Esophageal Cancer
- ☐ Stomach Cancer
- ☐ Ulcers
- ☐ Celiac Sprue
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Colon Polyps/Colon Cancer
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Heart Disease/ Stents
- ☐ CHF
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Asthma
- ☐ COPD
- ☐ Anemia
- ☐ Seizures
- ☐ Migraines
- ☐ Sleep Apnea
- ☐ Hearing Loss
- ☐ Cancer _____

SMOKING

☐ Yes
☐ No

Pk/Yrs: _____

Yr Quit: _____

ALCOHOL

☐ Yes
☐ No

Drinks/day: _____

Yr Quit: _____

FAMILY HISTORY OF COLON CANCER?

☐ Yes If yes, who? _____
☐ No

LAST COLONOSCOPY

Year? _____ Polyps _____ > 3 Years _____

FAMILY HISTORY OF POLYPS?

☐ Yes If yes, who? _____
☐ No

LAST UPPER ENDOSCOPY

Year? _____

RECREATIONAL DRUGS

☐ Yes
☐ No

Type _____

SURGERIES

_____
_____
_____

Do you have pain now or have you had pain in the last several weeks?

☐ Yes ☐ No If yes, rate level of pain on a scale of 1-10 with 10 being the worst: _____

Describe the pain: Where is it located? _____

What aggravates it? _____ How long does it last? _____

Prior Problems with anesthesia?

☐ Yes ☐ No If yes, please describe: _____

Do you have any physical, psychological, or emotional needs? _____

_____

Are you able to perform activities of daily living without assistance? ☐ Yes ☐ No

REASON FOR PROCEDURE

_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient's Signature Date

_____ _____
Nurse's Signature Date

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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
PO Box 570
Jefferson City, MO 65102
(573) 751-6302
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) 663-4227

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FINANCIAL DISCLOSURE AND AGREEMENT

There are separate service components for which you will be billed separately:

1. PHYSICIAN'S PROFESSIONAL CHARGE

Gateway Gastroenterology will bill for the Physician's Professional Charge and for the Anesthesia charges. This billing is for the physician's professional services that are provided during the procedure and the anesthesia used.

2. FACILITY CHARGE

Gateway Endoscopy Center (GEC), the facility, will bill a fee based on the type and number of procedures being performed. The charges will be billed under Mason Ridge Surgery Center LP. When calling your insurance to verify benefits use Tax Id# 20-5953364.

3. LABORATORY AND PATHOLOGY CHARGE

If you have a biopsy done or polyp(s) removed, you will receive a bill from the laboratory that processed your pathology. In some cases, the laboratory and pathology charges will be billed by Gateway Gastroenterology.

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

I agree to pay GEC in accordance with its regular rates and terms which are 30 days from date of invoice. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection including but not limited to attorney fees, court costs and filing fees.

I authorize direct payment to GEC of any insurance benefits. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

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

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signed _____ Date _____

Witness _____

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DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Prior to your procedure, you will be asked to sign a consent form such as the one below or one similar to it. Please read this, and if you have any questions, ask your physician prior to undergoing your procedure.

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedure.*

I (we) voluntarily request

☐ Jeffrey Kreikemeier, MD ☐ Brian McMorrow, MD ☐ Richard Riegel, MD ☐ Andrew Su, MD
☐ Jeffrey Mathews, MD ☐ Rajeev Ramgopal, MD ☐ Jonathan Seccombe, MD ☐ Fred Williams, MD

as my physician, and such associates, technical assistants, and other health care providers as he/she may deem necessary.

I (we) understand that the following surgical, medical, and/or diagnostic procedure(s) planned for me and I (we) voluntarily consent and authorize these procedures:

- ☐ Esophagogastroduodenoscopy with possible biopsy and/or polypectomy and/or dilation
- ☐ Colonoscopy with possible biopsy and/or polypectomy and/or dilation
- ☐ Flexible Sigmoidoscopy with possible biopsy and/or polypectomy and/or dilation
- ☐ Other: _____

I (we) understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I (we) authorize my physician, and such associated, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty, guarantee or assurance has been made to me as to the results of the procedure and that it may not cure my condition. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks, and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots, in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: drug reaction, bleeding, perforation, missed pathology, infection, cautery burn, cardiac arrhythmia, and aspiration.

I (we) understand that anesthesia involves additional risks and hazards, but I (we) request the use of anesthesia for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be charged possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetics including respiratory problems, drug reactions, paralysis, brain damage and even death.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedure to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

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INFORMATION RELEASE

I _____ give consent for any medical information to be released to the following parties:

(Print Patient's Name Here)

INFORMATION TO BE RELEASED TO THE FOLLOWING PARTIES:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

It is the patient's responsibility to contact this office if any name listed above would need to be removed.
A new consent form would need to be filled out.

_____ _____

Patient Signature Date of Birth

_____

Date

_____

Witness