



## ENDOSCOPY PREPARATION INSTRUCTIONS

Your procedure is scheduled for \_\_\_\_\_ at \_\_\_\_\_

**St. Luke's Hospital  
232 S. Woods Mill Road  
East Medical Building, Suite 130  
Chesterfield, MO 63017  
(314) 542-4863**

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

From Hwy 40/Interstate 64:

- Go north on Woods Mill Road (Hwy 141) ½ mile to Conway Road.
- Turn right at the stoplight onto Conway Road. Turn left into the hospital east entrance.
- Turn left again into the east surface parking lot or East Garage (3 levels). There is direct access to the East Medical Building from Level 1 or 3. Complimentary valet parking is available and is highly encouraged. Valet parking begins at 7:30am.

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.**

**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:**

- You may take your usual medications with sips of water as early as possible the day of the procedure.
- Arrive at St. Luke's GI/Endoscopy Lab **1 hour prior** to your scheduled procedure time.
- **SOMEONE WILL NEED TO DRIVE YOU TO AND FROM THE HOSPITAL.**
  - 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 medication form

## **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](http://www.gatewaygi.com)) for more detailed information regarding the physician you will be seeing and other services offered.**



## 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

## 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.



**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



## MEDICATION RECONCILIATION FORM

For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below. Thank You!

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICATION ALLERGIES AND REACTIONS

Check if No Known Drug Allergies

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### MEDICATION LIST

Medication Name (Prescription Medications)	Dosage	Frequency (How Often)	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

List name(s) of any Over the Counter Medications/Herbal Supplements

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### PHARMACY NAME

Local: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mail Order: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## FINANCIAL DISCLOSURE

Dear Patient:

We would like to take this opportunity to welcome you, and to 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 related to your charges:

### 1. PHYSICIAN'S PROFESSIONAL CHARGE

We will bill this charge for you. This billing is for the physician's professional services that are provided during your procedure.

### 2. FACILITY CHARGE

There will also be a facility bill for the use of the facility in which your procedure is being performed. If the procedure requires additional services, the billing will be increased depending on the added requirement. The facility will bill these charges separately to you

### 3. LABORATORY AND PATHOLOGY CHARGE

If you have a biopsy taken, or polyps removed, you will receive a bill from the laboratory that processes your biopsy.

### 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 facility on the day of the 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 payment for services provided. Our office will bill your insurance first. After your insurance processes the claim, we will forward a statement to you if there is any patient responsibility. Please remit payment in a timely fashion or call the office to make payment arrangements.

If you belong to an insurance plan, we will follow guidelines set forth in those plans. Please be sure to contact your primary care physician if your insurance requires a referral. Services cannot be rendered if proper authorization has not 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 are willing to work with you, but we need you to communicate with us. We do use outside agencies as a means of collections should we deem it necessary.

If you have any questions about the above information or any uncertainty regarding insurance coverage, don't hesitate to ask us. We are here to help you. You can reach our office at 314-529-4900.



## 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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Jeffrey Kreikemeier, MD | <input type="checkbox"/> Brian McMorrow, MD  | <input type="checkbox"/> Richard Riegel, MD    | <input type="checkbox"/> Andrew Su, MD     |
| <input type="checkbox"/> Jeffrey Mathews, MD     | <input type="checkbox"/> Rajeev Ramgopal, MD | <input type="checkbox"/> Jonathan Seccombe, MD | <input type="checkbox"/> 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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_____	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