WASHINGTON GASTROENTEROLOGY

Bellevue/Eastside Division

EASTSIDE ENDOSCOPY CENTER

Important Information About Your Procedure

Eastside Endoscopy - Bellevue
1135 116th Avenue, NE, Suite 570, Bellevue, WA 98004
p. 425.451.7335 | f. 425.451.1226

Eastside Endoscopy - Issaquah
1301 4th Avenue, NW, Suite 301, Issaquah, WA 98027
p. 425.270.6363 | f. 425.270.6625

EASTSIDE ENDOSCOPY CENTER

INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

It is very important to your doctor that you understand and consent to the treatment your doctor is rendering and any treatment your doctor may perform. You should be involved in any and all decisions concerning the procedures which you may need to have. Sign this form only after you understand the procedure, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

_____ _____

Patient's Signature or Authorized Individual Date

I hereby authorize and permit:

- ❑ Raj Butani, MD
- ❑ Kalle Kang, MD
- ❑ Sang Kim, MD
- ❑ Edwin Lai, MD
- ❑ Venkatachala Mohan, MD
- ❑ Georgia Rees-Lui, MD
- ❑ Roanne Selinger, MD
- ❑ Shie-Pon Tzung, MD
- ❑ Robert Wohlman, MD
- ❑ Eric Yap, MD

and any associates or assistants including the CRNA the doctor deems appropriate, to perform on me the following:

- ❑ Upper Endoscopy (EGD) with possible dilation
- ❑ Flexible Sigmoidoscopy
- ❑ Enterscopy
- ❑ Colonoscopy
- ❑ Variceal Banding
- ❑ EIS (Injection Sclerotherapy)
- ❑ Other: _____

The doctor has explained the benefits of gastrointestinal endoscopy to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I am aware that the practice of medicine and surgery are not an exact science. I also authorize the administration of IV sedation as may be deemed advisable or necessary for my comfort, well-being and safety. I have been informed by my physician and the staff of Eastside Endoscopy Center that if I receive sedation, I should not operate a motor vehicle for twelve hours following the procedure.

Explanation of the Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may also be removed.

Brief Description of Endoscopic Procedures

EGD (Esophagogastroduodenoscopy): Examination of the esophagus, stomach and duodenum. If active bleeding is found, coagulation by heat may be performed.

Dilation: Dilating tubes or balloons are used to stretch narrow areas of the intestinal tract.

EIS (Endoscopic Injection Sclerotherapy): Injection of a chemical into varices (dilated veins of the esophagus) to sclerose (harden) the veins to prevent further bleeding. Injection is done with a small needle probe through the endoscope.

Variceal Banding: The physician places a latex (rubber) band around the varices to reduce the flow of blood to the vein, thereby preventing future bleeding.

Flexible Sigmoidoscopy: Examination of the anus, rectum and left side of the colon, usually to a depth of 60cm.

Colonoscopy: Examination of all or a portion of the colon. The procedure may involve collection of a specimen.

Enteroscopy: Small intestinal endoscopy beyond the second portion of the duodenum and not including the ileum. The procedure may involve collection of a specimen.

Polypectomy: Using a wire loop and electric current, polyps (protruding growths) can be removed from the digestive tract; commonly done with colonoscopy and less commonly with EGD.

Monitored Anesthesia Care (MAC): Administration of IV medications by a CRNA to achieve a state of relaxation sufficient to improve tolerance for the procedure but not intended to result in significant depression of breathing or total inability to respond.

SAMPLE

Potential Risks and Complications

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure ***including, but not limited to***:

Perforation: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.

Bleeding: Bleeding, if it occurs, is usually a complication of biopsy, polyectomy or dilation. Management of this complication may consist of only careful observation, or may require transfusions or a surgical operation.

Moderate to Deep IV Sedation: Under this type of anesthesia, sedation is produced by injecting medicines into the bloodstream to make me unresponsive, but not unconscious. All types of anesthesia involve some risk. These risks include, but are not limited to allergic or adverse drug reactions, repiratory depression, hypoxia (low blood oxygen), low blood pressure, nausea, vomiting, arrhythmias (disorders of regular rhythmic beating of the heart), and injuries to the vein. Complications from anesthesia are uncommon but may occur. There is a remote possibility of death as a complication of anesthesia. No guarantee has been made that sedation will eliminate awareness, anxiety or discomfort.

Moderate to Deep IV Sedation Medication and Pregnancy: I understand that there are risks involved with IV sedation and to my knowledge I am not pregnant. If there is a question that I may be pregnant, then I will allow a urine pregnancy test to be performed prior to my procedure.

Medication Phlebitis: Medications used for sedation may irritate the vein into which they are injected. The irritation may result in a red, painful swelling of the vein and surrounding tissue that can become infected. Discomfort may persist for several weeks or months.

Missed Lesions (Polyps and Cancer): During your colonoscopy the physician will attempt to identify all polyps and cancer, and remove all polyps if possible. Although colonoscopy is the best test to find and remove these lesions, the exam is 90-95% accurate depending on multiple factors including prep quality.

Splenic Tear: As the scope passes through the splenic flexure in the colon, there is the rare possibility that an injury can occur to a patient's spleen. A splenic tear is an abrasion on the spleen that could result in hospitalization, the need for blood transfusion, and may even require surgery to treat.

Other Risks include, but are not limited to respiratory problems, decrease in blood pressure, allergic reaction, slurred speech, unaroused sleep, impaired cardiovascular function, aspiration and pneumonia, heart attack, damage to teeth or dental work (when instruments are inserted through the mouth), collapsed lung when visualizing the respiratory tract as well as nose and throat pain (a special tube may be placed into the chest to expand the lung when this occurs), clotting or infection in the vein where medication is given, and very rarely, death. Instrument failure is also extremely rare but remains a remote possibility. Drug reactions and complications from other diseases are possible.

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

In addition, older patients and those with extensive diverticulitis are more prone to complications.

All of the above complications are possible but occur with very low frequency. Occasionally, one or more of these complications could result in transfer to the hospital for hospitalization, blood transfusion, or the need for surgical intervention for correction. Your physician will discuss the frequency of these complications if you desire in reference to your own indications for the endoscopy.

In permitting my doctor to perform gastrointestinal endoscopy, I understand that unforseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above named physician, his/her assistants, and CRNA perform such procedures as necessary and desirable in the exercise of his/her professional judgement. I understand that Eastside Endoscopy Center's purpose is to perform elective endoscopy in a safe and uncomplicated manner. If a patient should have a complication, the center staff will always attempt to resuscitate the patient and transfer that patient to the hospital in the event of deterioration. *(RCW 70.122.060)*

Alternatives

The reasonable alternative(s) to gastrointestinal endoscopy, as well as the risks to the alternatives, has been explained to me. The alternatives include but are not limited to the following. Although gastrointestinal endoscopy is a safe and effective means of examining the gastrointestinal tract, it is not 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or a misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

SAMPLE

I hereby authorize the doctor to dispose of any removed tissues resulting from the procedure(s) authorized above.

I consent to the taking and publication of photographs taken during my procedure(s) for use in the advancement of medical education, **provided my identity is not revealed** by the pictures or by descriptive text accompanying them.

Written discharge instructions will be reviewed with me and a copy will be sent home with me. I will read and comply with them.

Any questions I had regarding gastrointestinal endoscopy and IV sedation that apply to my clinical circumstances have been answered to my satisfaction. The advantages and disadvantages of the endoscopy center versus the hospital setting have been discussed with me. I authorize the Certified Registered Nurse Anesthetists (CRNAs) of Paceline Anesthesia, PLLC to perform Monitored Anesthesia Care (MAC), commonly called IV sedation, and any other anesthetics as may be deemed advisable as a part of my upcoming GI procedure.

I have received verbal and written information regarding Advance Directives, Patient Rights & Responsibilities, and Physician ownership and have been given the opportunity to ask questions about them.

Date	Time	Signature of Patient or Authorized Individual	Relationship of Authorized Individual

WITNESS:

- ❑ The Patient/Authorized Individual has read the forms or had it read to him/her.
- ❑ The Patient/Authorized Individual expresses understanding of the form.
- ❑ The Patient/Authorized Individual has no questions.

Date	Time	Signature of Patient or Authorized Individual

CERTIFICATION OF PHYSICIAN

I hereby certify that I have discussed and explained the facts, risks, and the risks associated with the alternatives of the procedure(s) described in this Consent form with the individual granting consent.

Date	Time	Signature of Physician

CERTIFICATION OF CRNA

I hereby certify that I have discussed and explained the facts, risks, and the risks associated with the alternatives of the anesthesia described in this Consent form with the individual granting consent.

Date	Time	Signature of CRNA

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify) _____ Sign language

_____ Patient is blind, form read to patient _____ Other (specify) _____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual providing assistance)	Date	Time

SAMPLE

FREQUENTLY ASKED QUESTIONS

When do I have to stop drinking before the procedure?
Do not drink, chew gum or have lozenges for a full two hours before your procedure. Any fluid in your stomach puts you at risk for aspiration (inhalation of fluid into your lungs).

Why can't I go back to work or drive home?
The medications used to help you relax during your procedure will have an effect on your reflexes and judgement for 12 hours and may also have a temporary effect on your short term memory. For this reason, it is important to have someone you trust with you to hear your discharge instructions and make sure you arrive home safely. If you drive before these drugs are eliminated from your system it is considered "driving under the influence" and is punishable under the Washington State DUI Statute RCW 46.61.502. Our medical staff are obligated to report to the local police any patient who drives after receiving these drugs. We request that your escort remain in the building during your procedure.

Why do I have to fill out paperwork and answer questions at the endoscopy center when I already answered them at the doctor's office?
Medicare accredited facilities are required to have a separate chart for all patients. In addition, our nursing staff wants to make sure that we have your most up-to-date health information, including your current medications.

Will my insurance cover my procedure?
Many insurance carriers cover colonoscopy and upper endoscopy procedures. All insurance plans are different so it is important for you to contact your insurance company and discuss your benefits. You will be responsible for any co-pay or deductible. If you need assistance in determining your benefits, please call the Billing Office.

Why should I have my procedure done at Eastside Endoscopy Center?
Eastside Endoscopy Center's highly skilled team of doctors and nurses are committed to providing the highest quality endoscopic services in a comfortable atmosphere. We specialize in gastroenterology and endoscopy procedures. In addition, Eastside Endoscopy Center has been accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) since 1996. Eastside Endoscopy Center was the first endoscopy center in Washington State to achieve this voluntary accreditation.

I have concerns about the procedure, is there someone I can call?
If you have specific concerns about the day of the procedure, please feel free to contact our office and speak with one of our nurses. If you have questions about the preparation before your procedure, please contact your gastroenterologist's office.

What medications do you use?
Our CRNA's may use several medicines specifically selected for you based upon your health history. Medications commonly used are Propofol (a sedative), Fentanyl (a narcotic used to control pain), and Versed (a medicine used to promote relaxation).

Can I take my normal medications?
Yes. You should take all of your normal medications. The only exception to this may be blood thinning products, insulin and fish oil. Please check with your physician prior to your procedure about taking these drugs. If you use an inhaler, please bring it with you.

How soon after the procedure can I eat?
You can resume your normal diet after the procedure. If you had an upper Endoscopy, your throat may be sprayed with a numbing medicine. Your recovery nurse will instruct you when it is safe to resume your diet after receiving this spray.

I finished my colonoscopy prep and I am not sure the preparation worked. What should I do?
If you have completed your entire prep and you are still passing formed stool, your procedure may need to be rescheduled. Contact the Endoscopy Center as soon as possible and request to speak with a nurse.

Who do I contact about my bills?
When you have a procedure at Eastside Endoscopy Center, your insurance company will be billed by the following entities:

Eastside Endoscopy Center (EEC): EEC will bill your insurance for facility costs which include the equipment, procedure room, supplies, staff cost and medications.

Paceline Anesthesia: Paceline will bill your insurance for the services provided by the anesthesia professional. For any questions related to anesthesia, please call Paceline Anesthesia at 425.407.1500.

Washington Gastroenterology Laboratory: If you have polyps removed, or biopsies taken the lab will bill your insurance for the laboratory's processing and the pathologist's interpretation of the results of the biopsy specimens.

Washington Gastroenterology: Washington Gastroenterology will bill your insurance for physician services.

All other billing questions can be directed to the Billing Office: 800.734.6855

- Attached you will find copies of the forms you will be asked to sign when you check in for your procedure.
- Please take the time to review the forms and contact us if you have any questions.
- Read your preparation instructions carefully!
- Make sure you have a ride home. Your procedure will be rescheduled if you do not have a ride.

Please visit our website at www.washgi.com to join our Patient Portal.

We look forward to seeing you!

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www.eecendo.com

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WASHINGTON GASTROENTEROLOGY

Notice of Privacy Practices Acknowledgement

Washington Gastroenterology and its affiliated healthcare partners who constitute a clinically integrated organized healthcare arrangement: Western Washington Endoscopy Center, Eastside Endoscopy Center, Gastroenterology Associates Endoscopy Center, Narrows Anesthesia Services and Paceline Anesthesia, has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describe how your healthcare information may be used and disclosed, how you can access your health information, and whom to contact if you have questions, concerns, or complaints. You have the right to review our Notice of Privacy Practices before signing this acknowledgement.

We may change the Notice of Privacy Practices at any time. You may contact our office to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By signing this form, I acknowledge receipt of the Notice of Privacy Practices, or that I have been given the option to receive a copy of the Notice of Privacy Practices.

I authorize Washington Gastroenterology to disclose personal health care information and/or review my care with the following family members, friends or individuals involved in my care. This permission will be binding until revoked in writing by me.

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

Emergency contact(s) if not listed above:

Name _____ Relationship to me _____ Phone _____

Name _____ Relationship to me _____ Phone _____

I authorize Washington Gastroenterology to leave detailed personal messages for the purpose of appointment confirmation, test results, and/or to communicate with me about my health care information.

- ❑ Home _____
- ❑ Cell _____
- ❑ Work _____
- ❑ I do not authorize detailed messages to be left on any phone numbers listed for me.

_____ _____

Printed Name of Patient | Date of Birth

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient's Representative (if signing above) | Relationship to Patient

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For Office Use Only

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below.

Reason(s) _____

Staff member initials _____ Date _____

WASHINGTON GASTROENTEROLOGY

FINANCIAL RESPONSIBILITY - EASTSIDE ENDOSCOPY CENTER

It is your responsibility to confirm your insurance benefits with your insurance carrier prior to your appointment. We participate in most major insurance plans, including Medicare. We will bill participating insurance companies directly as a courtesy to you. You are responsible to verify your benefits for all services provided. If you receive non-covered benefits you will be responsible for any charges. If a referral or authorization is needed, check with your insurance to make sure it is in place prior to your appointment.

We require proof of insurance at each visit. If your insurance has recently changed, please notify us when you check in for your appointment.

Your copayment is required when you check in for your appointment.

PLEASE READ - IMPORTANT INFORMATION REGARDING COLONOSCOPY APPOINTMENTS

Insurance benefits vary based upon the type of colonoscopy performed.
Please contact your insurance company directly to verify your coverage.

A screening colonoscopy is a procedure provided to the patient in the absence of signs and symptoms and no prior polyps for the purpose of testing for the presence of colorectal cancer or colorectal polyps.

A diagnostic colonoscopy is a procedure provided to the patient as a result of an abnormal finding, sign or symptom such as history of colon polyps, blood in the stool, changes in bowel movements, diarrhea, constipation, etc.

Once your insurance has processed your claim, a statement will be sent to you for any remaining patient responsibility amounts. Payment is due upon receipt of the statement. If your account is not paid timely and it is necessary to send to a third party for collections, you will not be able to schedule further appointments until you have paid in full. A $20.00 charge will be added for any NSF or returned checks from your bank.

Please visit www.washgi.com to pay your bill online.

Any procedure may generate up to four separate statements including:

Physician Fee
Facility Fee
Anesthesia Provider Fee - Please verify if this is a covered benefit under your plan.
Pathologist Fee (if biopsies are taken)

ASSIGNMENT OF BENEFITS

I have reviewed and verified my demographic information for this visit. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, or third party insurance to issue payment directly to Washington Gastroenterology for medical services rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any patient responsibility not covered by my insurance.

Patient Signature _____ Date _____

Please call our Billing Office at 800.734.6855 if you have any questions. We will be happy to assist you.