FILL OUT AND RETURN THE DAY OF PROCEDURE

MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME:____________________________ **DOB:**______________

PHARMACY NAME:________________ **LOCATION:**_________________ **PHONE#**________________

ALLERGIES: (SEE BELOW) MEDICATION: Y N FOOD (INCLUDING EGGS OR SOY) Y N LATEX Y N

MEDICATION or FOOD/REACTION	MEDICATION or FOOD/REACTION

(List **ALL** medications, OTC drugs, Herbal supplements) **EVEN IF YOU HAVE NOT TAKEN THEM TODAY**

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)	Start Date
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o BLOOD THINNERS (DENIES)		o		
o		o		
o		o		

ATTESTATION: The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Patient/Guardian Signature:______________________________ **Date:**________________

Nursing Use Only: Source: ___Patient ___Family ___List

Obtained By: Pre-OP RN Signature:____________________ **Date:**______________

Anesthesiologist________________________________ **Date:**______________

OR RN Signature:______________________________ **Date:**______________

You may safely resume taking all of the above medications after your procedure, including over the counter medications and dietary supplements prescribed by your physician. EXCEPTIONS SEE BELOW:

Medication Dosage/Frequency	Resume Medication Date/Time

New Medication Prescribed Following Your Procedure

Medication	Dosage/Route/Frequency	Next dose

PACU RN Signature:______________________________ **Physician Signature:**___________________________

Rev. 11/19

DIGESTIVE HEALTHCARE CENTER
Patients Come First

CHARLES A. ACCURSO, M.D., F.A.C.G.
GARY F. CIAMBOTTI, M.D.
CORY D. VERGILIO, M.D.
ALAN R. GINGOLD, D.O.
CLAUDIA BARGHASH, M.D.
MARK L. GREAVES, M.D.
NADER YOUSSEF, M.D., F.A.C.G.
GINA THEOFANIDIS, MSN., R.N., A.P.N.-C

Dear Patient,

In preparation for your procedure which has been scheduled at Central Jersey Ambulatory Surgical Center, LLC, we ask that you review this packet as soon as possible.

This packet includes:

1. **Medication/Allergy Form – Please complete and bring day of procedure.**
2. Procedure preparation instructions
3. Anesthesia instructions
4. Informed consent for Gastrointestinal endoscopy
5. Facility disclosure of advance directives
6. Patient rights and responsibilities
7. Disclosure

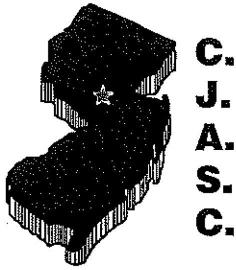
This will allow you the time to prepare and understand the paper work you will be asked to read and sign the day of the procedure. This will help us to achieve our goal of keeping our patients well informed.

Please call with any questions you may have. We look forward to seeing you on the day of the procedure.

Charles A. Accurso, M.D., F.A.C.G.
Gary F. Ciambotti, M.D.
Cory D. Vergilio, M.D.
Alan R. Gingold, D.O.
Claudia Barghash, M.D.
Mark L. Greaves, M.D.
Nader Youssef, M.D., F.A.C.G.
Gina Theofanidis, MSN, R.N., A.P.N.-C

511 Courtyard Drive • Bldg. 500 • Hillsborough, NJ 08844 • Tel. (908) 218-9222 • Fax (908) 218-9818
412 Courtyard Drive • Bldg. 400 • Hillsborough, NJ 08844 • Tel. (908) 218-9222 • Fax (908) 218-9818
319 East Main St. • Somerville, NJ 08876 • Tel. (908) 203-0900 • Fax (908) 203-0990
31 Mountain Blvd. • Suite H • Warren, NJ 07059 • Tel. (908) 546-7678 • Fax (908) 546-7960

www.DHCCENTER.com



CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey 08844
Bldg. 500 - 1st Floor • Phone: 908-895-0001 • Fax: 908-685-8833

Accredited by the

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Dear Patient,

Your Physician has scheduled you for a procedure in the Central Jersey Ambulatory Surgical Center. We are proud to inform you that we are accredited by Accreditation Association for Ambulatory Health Care, Inc.

**** IT IS STATE REGULATION THAT YOUR PROCEDURE BE SCHEDULED <u>WITHIN 30 DAYS</u> OF YOUR OFFICE VISIT****

It is very important that you read in full, the entire packet of information given to you. You can expect to be in the Center for approximately an hour and a half. If your driver is not going to wait for you in the Center, please have them come back to pick you up in an hour and a half. If you prefer, we can give them a call at the conclusion of your procedure. **<u>WE ASK THAT ALL RIDES ARRIVE WITHIN 30-45 MINUTES AFTER THE PATIENT'S PROCEDURE IS COMPLETED.</u>**

Please call our Center if you have any questions or go to [www.cjasc.com]. You may also ask for me, or if I am not available one of our Nurses will gladly assist you. I do ask that you please **<u>do not</u>** leave messages on the voice mail. Sometimes these messages are left on phones that are not regularly attended and we do not want to miss your call.

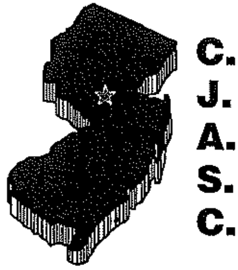
The staff and I at the Center look forward to assisting you before, during and after your scheduled visit.

Sincerely,

C. Sherman

Christin Sherman, RN,BS
Director of Nursing

Rev. 11/19



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LOCATED ON THE SOMERVILLE BORDER – 2 MILES SOUTH OF THE SOMERVILLE CIRCLE

From Somerville Circle:
Take **Route 206 South** and proceed 3 miles to Brown Avenue (U-Turn). Take U-Turn and turn left onto Route 206 North. Proceed approximately one mile on Route 206 **North**. Go **through** the traffic light at **Duke's Parkway West**. We are the **2nd Driveway after this traffic light on the right hand side**. **There is a Green Street Sign at the entrance that says, "DUKES PARKWAY EAST 1200 FEET."** The name of the complex is "The Courtyard." Enter the complex, make a right at the stop sign and then a left. Proceed to the last building on the left (Building 500).

From Southern New Jersey taking 287 North:
Take 287 North to Route 22 West (You must be in the left lane for this exit). Proceed to exit for Route 202/ 206 Somerville. Follow signs for Route 206 South to the Somerville Circle. Then follow directions listed above: "From Somerville Circle."

From Southern New Jersey taking 206 North:
Take Route 206 North to Hillsborough. Look for the K-Mart shopping center on the left. (Our office complex is 1.8 miles on the right after the K-Mart). After the light at Brooks Boulevard get into the right lane. Go through the next light, Dukes Parkway West, and our office complex, **THE COURTYARD, is the 2nd Driveway after this light**. **There is a Green Street Sign at the entrance that says "DUKES PARKWAY EAST 1200 FEET**." Enter the complex **here** and make a right at the stop sign and then a left. Proceed to the last building on the left (Building 500).

From Northern New Jersey:
Take I-287 South to Exit 17 onto Route 202-206 South. Follow the signs for Route 206 South to the Somerville Circle. Then follow directions above: "From Somerville Circle."

From Eastern NJ on Route 22 East:
Take Route 22 East and follow signs for Route 202/206 South towards Somerville. Once at the circle follow directions above: "From Somerville Circle."

From Western NJ on Route 22 West:
Take Rt. 22 West and follow signs for Route 202/206 South, Somerville. Proceed to the Somerville Circle and then follow directions above: "From Somerville Circle."

From the NJ Turnpike:
Take Exit #9 off the NJ Turnpike towards Route 18 North-New Brunswick. Continue on Route 18 to River Road ramp towards Piscataway. Take River Road to Route 287 North.(Approx 4 miles). Get onto Route 287 North and follow directions above: "From Southern NJ taking 287 North:"

Patient Rights and Responsibilities

Patients have rights and responsibilities as defined by the Patient's Bill of Rights and as supported by the State of New Jersey.

Legal Rights

- To treatment and medical services without discrimination based on age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment.
- To exercise all your constitutional, religious, civil, and legal rights.

Medical Care

- To receive the care and health services that the healthcare facility is required to provide.
- To receive an understandable explanation from your physician of your complete medical condition, recommended treatment, expected results, risks involved, and reasonable medical alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation will be given to your next of kin or guardian.
- To give informed written consent prior to the start of specified, non-emergency medical procedures or treatments only after your physician has explained to you, in words you understand, specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives.
- To refuse medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life threatening or the procedure is required by law.
- To be included in experimental research only if you give informed, written consent. or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. You have the right to refuse to participate.

Pain Management

- To pain relief.
- To have appropriate assessment and ongoing reassessment of pain.
- To have appropriate management of pain taking into account personal, cultural, spiritual and/or ethnic beliefs.
- To receive information and education regarding pain, management of pain, potential limitations and potential side effects of pain treatment.

Communication & Information

- To be informed of the names and functions of all health care professionals providing you with personal care.
- Disclosure of physician financial interests or ownership in the Center.

- To change your provider if other qualified providers are available.
- To receive, as soon as possible, the services of a translator or interpreter if you need one to help you communicate with the facility's health care personnel.
- To receive communication services if you have vision, speech, hearing, or cognitive impairments in a manner that meet your needs.
- To be informed of provisions for after-hours and emergency care.
- To be informed of the names and functions of any outside health care and education institutions involved in your treatment. You may refuse to allow their participation.
- Advance directives, as required by state or federal law and regulations and if requested, official State advance directive forms.
- To receive, upon request, the facility's written policies and procedures regarding life-saving methods.
- To be advised in writing of the facility's rules regarding the conduct of patients and visitors.
- To receive a summary of your patient rights that includes the name and phone number of the healthcare facility staff member to whom you can ask questions or complain about any possible violation of your rights.
- Marketing or advertising regarding the competence and capabilities of the organization that is not misleading.
- To be informed of appropriate information regarding the absence of malpractice insurance coverage if applicable.
- The organization will inform the patient or surrogate decision maker about unanticipated outcomes of care, treatment, or services that relate to sentinel events.

Medical Records

- To have prompt access to the information in your medical record. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your record.
- To obtain a copy of your medical record, at a reasonable fee, within 30 days after written request to the facility.
- To access your record pursuant to the provisions of N.J. Admin. Code § 8:43G-15.3 of the Public Health Law.

Cost of Facility Care

- To receive a copy of the facility fees for services, eligibility for third party reimbursement and, when applicable, the availability of free or reduced cost care payment rates. If you request an

itemized bill, the facility must provide one and answer any questions you may have. You have a right to appeal any changes.

- To be informed by the facility if part or your entire bill will not be covered by insurance. The facility is required to help you obtain any public assistance and private health care benefits to which you may be entitled.

Privacy & Confidentiality

- To have physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
- To be treated with courtesy, consideration, respect, and recognition of your dignity, individuality, and right to privacy, including, but not limited to auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
- To confidential treatment of information about you. Information in your records will not be released to anyone outside the healthcare facility without your approval, unless it is required by law. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

Freedom from Abuse & Restraints

- To freedom from verbal, physical, sexual and mental abuse.
- To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of you or others.

Transfers

- To be transferred to another facility only when you or your family has made the request, or in instances where the facility is unable to provide you with the care you need.
- To receive an advanced explanation from a physician of the reasons for your transfer and possible alternatives.

Personal Needs

- To be treated with courtesy, consideration, and respect for your dignity and individuality.
- To have access to storage space for private use. The facility has a system to safeguard your personal property.

Private Duty Nursing

- To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her care. A registered professional nurse so contracted shall adhere to healthcare facility policies and procedures so long as these requirements are the same for private duty and regularly employed nurses. The facility, upon request, shall provide the patient or designee with a list of local non-profit professional nursing association registries that refer nurses for private professional nursing care.

Discharge Planning

- To receive information and assistance from your attending physician and other health care providers if you need to arrange for continuing health care after your discharge from the facility.

- To receive sufficient time before discharge to arrange for continuing health care needs.
- To be informed by the healthcare facility about any appeal process to which you are entitled by law if you disagree with the facility's discharge plans.

Patient Guardian

The patient's guardian, next of kin, or legally authorized responsible person has the right to exercise the rights delineated on the patient's behalf, to the extent permitted by law, if the patient has been adjudicated incompetent in accordance with the law, has designated a legal representative to act on his / her behalf or is a minor.

Patient Rights Notification

You or your representative will be notified of your rights, both verbal and written, prior to the start of the procedure in a language and manner that you understand.

Patient Responsibilities The patient has the responsibility to do the following:

- *The patient is encouraged to ask any and all questions of the physician and staff in order that he/she may have a full knowledge of the procedure and aftercare.*
- *Follow the treatment plan prescribed by his/her provider and participate in his/her care.*
- *Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.*
- *Provide the organization with information about their expectations of and satisfaction with the organization.*
- *Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.*
- *Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.*
- *Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.*
- *Accept personal financial responsibility for any charges not covered by his/her insurance.*
- *Be respectful of all the health care providers and staff, as well as the other patients.*

Patient Questions & Complaints

- To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice free from restraint, interference, coercion, discrimination, or reprisal.
- A complaint or grievance should be registered by contacting the center administrator and/or patient advocate through the State Department of Health or Medicare. All complaints and grievances will be logged with the specific issue reported, the date the report was received (verbal or written), the resolution and the date of closure. The center will respond in writing with notice of how the grievance has been addressed within 30 days.

Administrator
Central Jersey Ambulatory Surgical Center
511 Courtyard Drive,
Hillsborough. N.J. 08844
Tel: 908) 895 0001

Medicare Beneficiary Ombudsman
1-800-MEDICARE 1-800-633-4227
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
P.O. Box 367
Trenton, NJ 08625-0367
Toll Free Hotline: 1-800-792-9770, Select #1
Fax: 609-943-4977 or 609-633-9060

Office of the Ombudsman for the Institutionalized Elderly
P.O. Box 852
Trenton, NJ 08625-0852
Toll Free Hotline: 1-877-582-6995
Fax: 609-943-3479
E-mail: PublicAdvocate@advocate.state.nj.us
References: NJAC 8:43A-16.2, (a) 1-14

For concerns about patient safety and quality of care that you feel have not been addressed appropriately by the center Administrator, you can also contact:
The Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road Suite 200
Skokie, IL 60077
E-mail: info@aaahc.org
Tel: 847-853-6060 Fax: 847-853-9028

Advance Directives

In accordance with N.J. Stat. § 26:2H-53 we must inform you of the center policy on Advance Directives. Advance directives include but are not limited to a **health care proxy**, consent to a **do-not-resuscitate (DNR) order** recorded in your medical record and a **living will.**

Due to the fact that the Ambulatory Center for Endoscopy is an Ambulatory Surgery Center for the purpose of performing elective Endoscopy in a safe and uncomplicated manner, patients are expected to have an excellent outcome. If a patient should have a complication, the center staff will always attempt to resuscitate the patient and transfer that patient to a hospital in the event of deterioration.

If a patient should provide his/her Directive, a copy will be placed on the patient's medical record and transferred with the patient should a hospital transfer be ordered by his/her physician

In order to assure that the community is served by this center, information concerning advance directives/Healthcare proxy and DNR orders are available at the center and:

Information on Advance Directives

Help Line: 800-658-8898 **Multilingual Line: 877-658-8896**
Email: caringinfo@nhpco.org **Website: www.caringinfo.org**

To hear Patients Rights and Responsibilities verbally
Dial 908 895 0001 extension 350

The list of patient rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of the healthcare facility patients. For more complete information, consult NJ Department of Health regulations at NJAC 8:43G-4 or Public Law 1989-Chapter 170, available by asking the Facility.

Updated March 2016

ANESTHESIA INSTRUCTIONS

1. YOU WILL BE RECEIVING SEDATION FOR THE PROCEDURE YOUR DOCTOR HAS SCHEDULED. IT IS VERY IMPORTANTANT THAT YOU READ THE FOLLOWING CAREFULLY.
2. YOU MUST ARRANGE FOR A RESPONSIBLE ADULT (18 YEARS OR OVER) TO DRIVE YOU HOME. TAXI'S ARE NOT ALLOWED. IF TRANSPORTATION IS AN ISSUE THERE IS A SERVICE WE CAN REFER YOU TO.
3. WEAR LOOSE, COMFORTABLE CLOTHING SUCH AS A SWEAT PANTS & T-SHIRT. NO JEANS, METAL ZIPPERS, BRA HOOKS (SPORTS BRAS ONLY).
4. IF YOU ARE OF CHILD BEARING YEARS (15-50), A URINE PREGNANCY TEST WILL BE PERFORMED UPON YOUR ARRIVAL. PLEASE DO NOT EMPTY YOUR BLADDER PRIOR TO SEEING THE PRE-OP NURSE.
5. NO PRODUCTS CONTAINING MARIJUANA SHOULD BE CONSUMED AFTER MIDNIGHT PRIOR TO THE PROCEDURE. (THIS INCLUDES SMOKING, VAPING, EDIBLE CONSUMPTION ETC.)

BEFORE THE PROCEDURE:

1. PLEASE FOLLOW THE DIETARY INSTRUCTIONS THAT HAVE BEEN GIVEN BY YOUR DOCTOR.
2. YOU MAY HAVE CLEAR LIQUIDS UP UNTIL 4 HOURS PRIOR TO YOUR PROCEDURE (NO MILK, DAIRY PRODUCTS OR ORANGE JUICE). **REFER TO YOUR DIETARY INSTRUCTIONS FOR EXAMPLES OF CLEAR LIQUIDS.
3. MEDICATIONS: TAKE YOUR MEDICATIONS AT LEAST 4 HOURS PRIOR TO THE PROCEDURE. THESE INCLUDE HEART, BLOOD PRESSURE, THYROID AND ANTI-SEIZURE MEDICATION. (CONTINUE TO WEAR YOUR NITROGLYCERINE PATCH IF PRESCRIBED BY YOUR DOCTOR.) ASTHMA MEDS: TAKE INHALERS AS DIRECTED AND BRING WITH YOU.
4. BLOOD THINNERS: COUMADIN, PLAVIX, XARELTO, PRADAXA, PLETAL, EFFIENT, ASPIRIN. THESE MEDICATIONS MAY NEED TO BE STOPPED SEVERAL DAYS PRIOR TO YOUR PROCEDURE. PLEASE ASK YOUR DOCTOR.
5. DIABETICS: TO AVOID LOW BLOOD SUGARS, DO NOT TAKE YOUR PILLS ON THE MORNING OF THE PROCEDURE. YOU CAN RESUME THEM AFTER THE PROCEDURE WHEN YOU HAVE SOMETHING TO EAT. IF YOU TAKE INSULIN YOU SHOULD HOWEVER TAKE HALF THE DOSE AND BRING YOUR INSULIN WITH YOU.
   CHECK YOUR SUGARS FREQUENTLY
6. DEFIBRILLATORS: IF YOU HAVE A DEFIBRILLATOR YOUR PROCEDURE WILL BE SCHEDULED AT ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL.
7. SMOKERS: IT IS ADVISED THAT YOU DO NOT SMOKE AT LEAST 6 HOURS PRIOR TO THE PROCEDURE.

AFTER THE PROCEDURE:

1. THE EFFECTS OF THE SEDATION CAN PERSIST FOR 24 HOURS.YOU MUST EXERCISE EXTREME CAUTION BEFORE ENGAGING IN ANY ACTIVITY THAT COULD BE HARMFUL TO YOURSELF OR OTHERS (SUCH AS DRIVING A CAR). DO NOT MAKE ANY IMPORTANT DECISIONS, AND DO NOT DRINK ALCOHOLIC BEVERAGES DURING THIS TIME.
2. YOU MAY HAVE ANYTHING YOU LIKE TO EAT OR DRINK AFTER THE PROCEDURE. YOU WILL PROBABLY WANT TO START WITH SOMETHING LIGHT, AND PLENTY OF FLUIDS. AVOID ITEMS THAT CAUSE GAS (SALADS, SODA, ETC.)
3. IF YOUR PROCEDURE REQUIRED A METAL CLIP. NO MRI FOR 30 DAYS.
4. CONTACT YOUR PHYSICAN SHOULD YOU HAVE ANY QUESTIONS OR CONCERNS.

CENTRAL JERSEY AMBULATORY SURGICAL CENTER
ADVANCE DIRECTIVES DISCLOSURE

There are several different types of Advance Directives, including Living will, Health Care Proxy, Do Not Resuscitate

A. Due to the elective nature of the procedures performed in this facility, Do Not Resuscitate orders are not honored in the facility. Patients wishing to maintain their status of Do Not Resuscitate will be given the option of scheduling their procedure in the hospital.

B. No patient will be discriminated against based on whether or not that individual has executed an advance directive.

C. Written information shall be provided to all adult patients at the time of admission concerning:

   1. An individual's rights under State law to make health care decisions, including the rights to accept or refuse medical or surgical treatment and the right to formulate advance directives;

   2. The Center's policy respecting these rights.

D. Written follow-up information will be provided to all interested adult patients, their families and health care representatives upon admission. Said information shall include information and materials about advance directives and a description of the process by which a patient may obtain assistance in the execution of an advance directive.

E. Physicians shall be encouraged to discuss advance directives with their patients prior to admission.

F. Patient and staff education regarding patient rights and advance directives will be provided by The Center.

G. A competent adult may execute an advance directive at any time. Once executed, the declarant may revoke an advance directive by the following means:

   1. Notification, orally or in writing, to the patient's health care representative (if any), physician, nurse or other health care professional, or other reliable witness, or by any other act evidencing an intent to revoke the document.

   2. Execution of a subsequent advance directive.

      i. An incompetent patient may suspend an advance directive by notification, orally or in writing, to the patient's health care representative (if any), physician, nurse or other health care professional, or other reliable witness, or by any other act evidencing intent to revoke the document.

H. Valid advance directives will become a permanent part of a patient's medical record when made available.

I. For more information and to download New Jersey's Advance Directive forms please visit: http://nj.gov/health/healthfacilities/documents/ltc/advance_directives.pdf

Central Jersey Ambulatory Surgery Center
Advance Directive/Living Will Declaration

Instructions: Consult this column for guidance.	To my family, Doctors, and all those concerned with my care
This declaration sets forth your decisions regarding medical treatment.	I, ______________________________, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.
You have the right to refuse the treatment you do not want, and you may request the care you do want.	These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in doing so to be free of any legal liability for having followed my directions:
You may list specific treatment you do not want: e.g., CPR, cardiac resuscitation-Mechanical respiration-Feeding Tubes-Intravenous Fluids. Your general statement above will suffice.	I especially do not want
You may want to add other instructions directing the care you do not want: e.g. pain management-to die at home.	Other instructions/comments
If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.	PROXY DESIGN CLAUSE: In order to carry out my instructions as stated above and to interpret them, I designate the following person to act on my behalf Name:______________________________ Address:____________________________ Home Phone #:________________ Work Phone #:
	If the person named above is unable to act on my behalf, I authorize the following person to do so: Name:______________________________ Address:____________________________ Home Phone #:________________ Work Phone #:________________

Patient's Signature:________________________ Witness:________________________

Date:____________ Date:____________

CENTRAL JERSEY AMBULATORY SURGICAL CENTER
511 Courtyard Dr., Hillsborough, NJ 08844
Tel: (908) 895-0001 Fax: (908) 685-8833

Patient Label

READ ONLY

INFORMED ENDOSCOPY CONSENT

A. The procedure(s) necessary to treat my condition (has, have been) explained to me by Dr. ______________________ and I understand the nature of the procedure to be (check where applicable). I hereby authorize him/her ("physician") and such assistants as may be selected to treat my condition.

- ☐ Flexible Sigmoidoscopy (insertion of tube into rectum/colon) with possible biopsy (tissue sample)
- ☐ Colonoscopy (insertion of tube into rectum/colon) with possible biopsy, polypectomy (polyp removal), injection therapy, or control of bleeding
- ☐ Hemorrhoidal Banding
- ☐ Esophagoscopy Gastroscopy Duodenoscopy (EGD) with possible biopsy (tissue sample) /cautery / dilation (stretching of a narrowing) / (Insertion of tube into throat, stomach and duodenum)
- ☐ Other: ____

B. It has been explained to me that there are alternatives to the aforementioned course of treatment including but not limited to:

- Contrast Radiographic Studies (Barium Enema or GI Series) – X-Rays
- Observation (not to do the procedure)

C. I have been made aware that the risks and consequences commonly associated with the procedure(s) described above may include but are not limited to:

- **Bleeding (increased risk if biopsy or polypectomy is performed) may require a blood transfusion.**
- **Perforation (a hole torn inside possibly requiring a procedure or surgery to be performed: the presence of extensive diverticulosis are more prone to complications)**
- **Infection (possibly requiring intervention, such as antibiotic treatment, surgery or other treatments)**
- **Aspiration (fluid entering the lungs)**
- **Post Polypectomy Burn Syndrome**
- **Dental Damage**

D. I have also been told that if the procedure is not performed, what may happen to me is: **The condition(s) may not be treated and/or diagnosed. There may be a delay in diagnosis and/or treatment. (Bleeding / tumor or growth / disease).**

E. It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) than those set forth above. I, therefore, authorize and request that the above named physicians, their assistants, or their designees perform such surgical or other procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all other conditions that require treatment and are not known to the above named physicians at the time of the operation or other procedure commenced.

F. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest – etc., that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and procedure is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. **Even the best experienced physicians can miss abnormal growths possibly related to poor prep, spasm, diverticular disease, etc.**

G. I consent to the retention or disposal of any tissue or parts, which may be removed.

H. I also authorize the presence of observers, as considered appropriate or advisable by the surgeon or his/her associate or assistant according to the center policy and in accordance with HIPAA and the state law.

I. If my physician or a member of the center staff has exposure to one of my body fluids during this procedure, I consent to the testing of my blood, including but not limited to the human immunodeficiency virus (HIV) and hepatitis.

J. I certify that I have read and fully understand the above consent; that the explanations therein referred to were made to me by the physician and that the statements requiring insertion or completion were filled in and paragraphs which I do not want to apply, if any, were stricken before I signed.

K. I have been provided the opportunity to read this consent and ask questions.

L. Residents are present at times during studies and they assist during some of the procedures when they are present.

M. I am aware that there could be a repeat procedure necessary if my bowel is insufficiently prepped, at an additional cost.

N. I am aware that my physician might decide to connect a device to the tip of the scope to increase visualization in order to improve polyp detection.

O. I have read and understand this consent form

X______________________________ DATE: ____________ ______________________________

Signature of Patient or legally authorized representative — Witness to Signature

______________________________ ______________________________

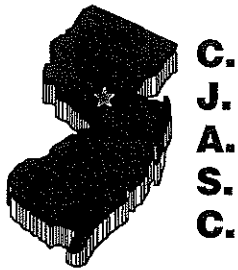
Relationship if not Patient — Signature of interpreter

PHYSICIAN'S CERTIFICATION

I, Dr. ______________________, certify that I have explained the specified operation(s) or procedure(s), the attendant risk and consequences, the alternatives, and the prognosis if the operation or other procedure is not performed, to the above named patient and/or other responsible person who has signed the above consent.

______________________________ ______________

Physician's Signature — Date



CENTRAL JERSEY AMBULATORY SURGICAL CENTER

511 Courtyard Drive, Hillsborough, New Jersey 08844
Bldg. 500 - 1st Floor • Phone: 908-895-0001 • Fax: 908-685-8833

Patient Name: ______________________________ DOB: ______________

Performing Physician: ______________________________________

READ ONLY

CONSENT FOR ANESTHESIA

I consent to the administration of Anesthesia or Sedation, and to the use of such Anesthetics or Sedatives as my physician may deem appropriate. I certify that I have read and fully understand this consent statement which has been preceded by an explanation of the risks, benefits, alternatives, and possible complications by my physician, that the explanations therein referred were made to me by Physician (Name) ____________________ and are understood by me, and that all blanks or statements requiring insertion or completion were filled in before I signed.

Anesthesia Plan: **DEEP SEDATION > CONSCIOUS SEDATION**

NO SEDATION

I hereby certify that the risks and benefits of the proposed procedure/treatment as well as the alternatives, have been explained to me by the physician or to the authorized person/ responsible other.

______________________________ ______________

Signature: PATIENT/AUTHORIZED PERSON DATE

______________________________ ______________

Signature: WITNESS DATE

______________________________ ______________

Signature: ANESTHESIOLOGIST DATE

CENTRAL JERSEY AMBULATORY SURGERY CENTER (CJASC)

READ ONLY

Patient Label

FACILITY CONSENT FORM

PATIENT'S NAME: ______________________

PHYSICIAN'S NAME: ______________________

CONSENT FOR TREATMENT:

I, THE ABOVE-NAMED AND UNDERSIGNED PATIENT, GIVE MY CONSENT FOR CARE AT AND BY THE MEDICAL, NURSING ALLIED PROFESSIONAL STAFF OF THE ABOVE SURGICAL CENTER, WHICH MAY INCLUDE ROUTINE DIAGNOSTIC PROCEDURES AND SUCH MEDICAL TREATMENT AS MY DOCTOR OR HIS/HER DESIGNEES MAY FIND ARE NEEDED. I ACKNOWLEDGE THAT NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF ANY EXAMINATIONS, TREATMENTS OR PROCEDURES I MAY RECEIVE WHILE AT THE CENTER.

RELEASE OF MEDICAL RECORDS:

I AUTHORIZE THE CENTER TO RELEASE ALL OR ANY PART OF MY MEDICAL RECORD TO (A) HOSPITALS OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES, WORKERS' COMPENSATION CARRIERS, WELFARE FUNDS OR OTHER ORGANIZATIONS OR AGENCIES THAT MAY BE CONCERNED WITH THE PAYMENT OF COSTS RELATED TO MY TREATMENT AND (B) ANY OTHER ORGANIZATION OR AGENCY TO WHICH THE CENTER IS PERMITTED TO RELEASE SUCH INFORMATION UNDER APPLICABLE LAWS. IN THE EVENT I AM TRANSFERRED OR ADMITTED TO A HOSPITAL POST-OPERATIVELY(or require Emergency Room care within 24 hours post-operatively), I AUTHORIZE THE CENTER TO OBTAIN A COPY OF THE HOSPITAL DISCHARGE SUMMARY.

FINANCIAL ARRANGEMENTS:

I AUTHORIZE AND DIRECT MY INSURER OR PAYOR TO PAY DIRECTLY TO THE ABOVE CENTER ANY OR ALL BENEFITS, UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT. I AGREE THAT, IN CONSIDERATION OF THE SERVICES THAT WERE PROVIDED TO ME, I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE AMOUNT PROMPTLY IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE FACILITY. I UNDERSTAND, THEREFORE, THAT TO THE EXTENT PERMITTED UNDER APPLICABLE LAWS AND CONTRACTUAL ARRANGEMENTS, I AM FINANCIALLY RESPONSIBLE TO THE CENTER FOR ANY AMOUNTS NOT COVERED BY INSURANCE. FURTHERMORE, I UNDERSTAND THAT MY INSURER OR PAYOR MAY REQUIRE CERTAIN HEALTH CARE SERVICES TO BE AUTHORIZED BEFORE THEY ARE FURNISHED TO ME. I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE CENTER WITH RESPECT TO THE SERVICES THAT I CHOOSE TO RECEIVE NOTWITHSTANDING THAT MY HEALTH INSURER OR PAYOR HAS REFUSE TO GIVE PREAUTHORIZATION FOR ALL OR ANY PORTION OF MY SERVICES.

PRE-CERTIFICATION:

YOUR INSURANCE COMPANY WILL BE CALLED TO PRE-CERTIFY YOUR PROCEDURE. PLEASE MAKE SURE THAT WE HAVE THE CORRECT INSURANCE INFORMATION. IT IS IMPORTANT TO NOTIFY US IF YOU HAVE DIFFERENT PLANS FOR PHYSICIAN AND HOSPITAL SERVICES.

☐ I UNDERSTAND I AM USING MY OUT OF NETWORK BENEFITS. THIS FACILITY IS NOT CONTRACTED WITH MY INSURANCE COMPANY TO PROVIDE SERVICES. I UNDERSTAND THAT THE REIMBURSEMENT MAY BE SENT TO ME INSTEAD OF THE CENTER. UPON RECEIPT OF THE INSURANCE PAYMENT, I WILL FORWARD THE CHECK AND THE EXPLANATION OF BENEFITS TO THE CENTER. I UNDERSTAND THAT MY INSURANCE PLAN MAY STILL HOLD ME RESPONSIBLE FOR A DEDUCTIBLE AND/OR COINSURANCE.

FACILITY CHARGE:

WHEN YOUR PROCEDURE IS PERFORMED AT THE ABOVE SURGICAL CENTER, THERE WILL BE A FACILITY FEE. THERE IS A CHARGE FOR THE USE OF THE SURGICAL SUITE FOR YOUR PROCEDURE. FEES WILL VARY ACCORDING TO THE TYPE OF PROCEDURE(S) THAT IS / ARE BEING PERFORMED. PATIENT RESPONSIBILITY IS DEPENDENT UPON INDIVIDUAL INSURANCE PLANS.

IF YOU HAVE ANY QUESTIONS REGARDING THE ABOVE INFORMATION, PLEASE SPEAK WITH THE ADMINISTRATOR.

COLLECTION EXPENSES: (MEDICARE/MEDICAID EXCLUDED)

SHOULD MY ACCOUNT WITH THE SURGERY CENTER BE REFERRED TO AN ATTORNEY OR OUTSIDE AGENCY FOR COLLECTION, I WILL PAY ALL REASONABLE COLLECTION EXPENSES (INCLUDING ATTORNEY'S FEES) ASSOCIATED WITH THE COLLECTION EFFORT. I ACKNOWLEDGE THAT ALL DELINQUENT ACCOUNTS WILL BEAR INTEREST AT THE LEGAL RATE.

CENTRAL JERSEY AMBULATORY SURGERY CENTER (CJASC)

additional charges

PROFESSIONAL FEES:

THESE ARE THE FEES THAT ARE BILLED BY YOUR PHYSICIAN FOR HIS SERVICES IN PERFORMING YOUR PROCEDURE. THESE FEES ARE WITHIN THE RANGE CONSIDERED USUAL AND CUSTOMARY FOR THIS AREA. PATIENT RESPONSIBILITY WILL VARY ACCORDING TO EACH INSURANCE PLAN.

FOR QUESTIONS PERTAINING TO YOUR PHYSICIAN'S BILL: PLEASE CONTACT YOUR SURGEON

ANESTHESIA:

A CERTIFIED ANESTHESIOLOGIST WILL BE PARTICIPATING IN YOUR PROCEDURE IN ORDER TO PROVIDE COMFORT AND SAFETY. THIS SERVICE WILL BE BILLED TO YOUR INSURANCE COMPANY.

BIOPSIES:

IF A BIOPSY IS REQUIRED DURING THE COURSE OF YOUR PROCEDURE, A TISSUE SAMPLE WILL BE SENT TO A LABORATORY TO BE ANALYZED BY A PATHOLOGIST. YOU MAY RECEIVE A SEPARATE BILL FROM THE PATHOLOGIST.

HIPAA:

- I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE HIPAA PRIVACY REGULATIONS.

PATIENT RIGHTS/ADVANCE DIRECTIVE/DISCLOSURE OF OWNERSHIP:

I HAVE BEEN OFFERED WRITTEN AND GIVEN VERBAL NOTIFICATION OF THE FOLLOWING:

- PATIENT RIGHTS & RESPONSIBILITIES.
- THE FACILITY POLICY ON ADVANCE DIRECTIVES
- DISCLOSURE OF OWNERSHIP (IF APPLICABLE)

ADVANCE DIRECTIVE/LIVING WILL:

- I HAVE AN ADVANCE DIRECTIVE OR LIVING WILL: ☐ YES ☐ NO
- I HAVE BROUGHT MY ADVANCE DIRECTIVE OR LIVING WILL WITH ME: ☐ YES (copy made) ☐ NO (forgot it)
- INFORMATION ON ADVANCE DIRECTIVES WAS OFFERED TO ME BY THE ASC ☐ YES ☐ NO

"It is the policy of the center, regardless of the contents of an Advance Directive or instructions from a Health Care surrogate or Power of Attorney that if an adverse event occurs during treatment, the center personnel will initiate resuscitative or other stabilizing measurers, and transfer the patient to an acute care hospital for further evaluation".

CLOTHING AND VALUABLES:

I FULLY UNDERSTAND THAT **CJASC** IS **NOT** RESPONSIBLE FOR ANY PERSONAL PROPERTY (CLOTHING, EYEGLASSES, DENTURES, ETC.) BROUGHT IN OR RETAINED IN THE LOCKERS AT ANY TIME. I FULLY UNDERSTAND THAT ANY VALUABLES (MONEY, JEWELRY, AND KEYS) SHOULD BE GIVEN TO A FAMILY MEMBER OR OTHER RESPONSIBLE PARTY FOR SAFE KEEPING.

ACKNOWLEDGEMENT OF DRIVING RISKS:

I HAVE BEEN INFORMED BY **CJASC** THAT I SHOULD NOT DRIVE FOR AT LEAST 24 HOURS AFTER COMPLETION OF MY PROCEDURE. A RESPONSIBLE ADULT, UPON DISCHARGE FROM **CJASC,** WILL ACCOMPANY ALL PATIENTS WHO HAVE RECEIVED GENERAL / INTRAVENOUS SEDATION / SPINAL / EPIDURAL ANESTHESIA. ALL PATIENTS WHO HAVE HAD LOCAL ANESTHESIA WITHOUT SEDATION, AND WHO MEET THE DISCHARGE CRITERIA MAY BE DISCHARGED UNESCORTED.

PATIENT SIGNATURE

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED TO HIM/HER, AND THE UNDERSIGNED IS SATISFIED THAT HE/SHE UNDERSTANDS ITS CONTENTS AND SIGNIFICANCE.

SIGNATURE OF PATIENT DATE

PATIENT IS A MINOR OR UNABLE TO SIGN BECAUSE:

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED, AND THE UNDERSIGNED IS SATISFIED THAT THE CONTENTS ARE UNDERSTOOD. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS BEEN DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S LEGAL REPRESENTATIVE OR GUARDIAN TO EXECUTE THE ABOVE AND ACCEPT ON BEHALF OF THE PATIENT.

SIGNATURE OF REPRESENTATIVE / LEGAL GUARDIAN DATE

READ ONLY

DISCLOSURE

Public law/rule of the Federal Government and the State of New Jersey Board of Medical examiners mandates that a physician, podiatrist and all other licenses of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Please take notice that the following practitioners have a financial interest in referring to

Central Jersey Ambulatory Surgical Center
511 Courtyard Drive,
Hillsborough
New Jersey
08844

You may, of course, seek treatment at a healthcare facility of your own choice. A listing of alternative healthcare facilities can be found in the classified section of your telephone directory under the appropriate heading.

C.J.A.S.C. is owned by Physicians Endoscopy and the following physicians:

Dr. Charles Accurso
Dr. Gary Ciambotti
Dr. Cory Vergilio
Dr. Claudia Barghash
Dr. Alan Gingold
Dr. Mark Greaves

What to Expect in Recovery after Your Procedure

Upon arrival to the recovery room you will be connected to monitors and your vital signs will be observed by your nurse for about 20 minutes. When you have awoken, you will be offered a drink and your nurse will provide you with your discharge instructions. Your physician will come to speak to you about your procedure and discharge you. If you feel that you will need someone with you when the physician is discussing your results, please let us know when we check you in at the front desk. You will be given a copy of your procedure report and discharge instructions, so you can review them later.

After leaving the facility, you will be able to eat something light. We recommend a breakfast such as eggs, toast or pancakes, or lunch such as soup or a sandwich. Since you received anesthesia, you are not allowed to drive, operate heavy machinery, sign any legal documents, or make important decisions. Return to your normal activity the following day. If you experience pain, fever, bleeding, or have any other questions or concerns you should call the doctor's office. There is always a doctor on call to speak with about concerns and can be reached at the office phone number, (908) 218- 9222.

You will receive a call the morning after your procedure from one of our nurses, beginning at 7:30 AM. They will be able to answer any questions you may have at that time.

INSURANCE TRANSPARENCY FORM

The information below will help you review your upcoming procedure with your insurance carrier to discuss how the insurance company will process your claim.

The Affordable Care Act passed in March 2010 established guidelines now used by the majority of insurance companies to define and process colonoscopies.

Preventive/ Screening/Routine Colonoscopy: **Procedure code (CPT) 45378* / 45380***
Diagnosis Code (ICD-10) Z12.11 - Encounter for screening for malignant neoplasm of colon

Patient is age 50 or over, has **no** gastrointestinal symptoms such as bleeding or constipation, has no personal or family history (parent, sibling or child) of gastrointestinal disease, colon polyps, and/or colon cancer. The patient did not have a previous colonoscopy within the last 10 years.

*****Colonoscopy Insurance claims are filed based on findings during the procedure*****

Surveillance/High Risk Screening Colonoscopy: **Procedure code (CPT) 45378* / 45380***

Patient has no gastrointestinal symptoms such as bleeding or constipation and has one or more of the following:

	Diagnosis Code (ICD-10)
• Personal history of adenomatous polyps	Z86.010
• Personal history of colon or rectal cancer	Z85.038, Z85.048
• Personal history of inflammatory bowel disease/ and/orCrohn's/Ulcerative colitis	Z87.19
• Family history (parent, sibling or child) colon or rectal cancer	Z80.0
• Family history (parent, sibling or child) adenomatous polyps	Z83.71
• Family history (parent, sibling or child) adenomatous polyposis of colon	Z83.71

Due to increased risk factors patients with these or related conditions/histories undergo colonoscopy surveillance at shortened intervals (every 2-5 years).

Diagnostic/Therapeutic Colonoscopy: **Procedure code (CPT) 45378* / 45380 ***

Patient has past and/or present gastrointestinal symptoms such as rectal bleeding, rectal pain, abdominal pain, cramping, weight loss/gain, anemia, and change in bowel habits, polyps, inflammatory bowel disease.

	Diagnosis Code (ICD-10)
• Abdominal pain:	R10.84
• Change in bowel habits:	R19.4
• Diarrhea:	R19.7
• Constipation:	K59.00
• Rectal bleeding:	K62.5
• Blood in stool:	K92.1
• Other ____________________	

***Note procedure & diagnosis codes listed above are the most common; many times there are other related codes that may be used based upon findings during your procedure.**

***45378 – Diagnostic Colonoscopy**
***45380 – Colonoscopy with Biopsy(s) take**

Upper Endoscopy **Procedure Code (CPT) 43235* / 43239***

Upper Endoscopies are **ALWAYS** considered to be a diagnostic procedure and will fall under your **MEDICAL BENEFITS**.

***43235 – Upper Endoscopy without biopsies**
***43239 – Upper Endoscopy with biopsies**

****Who will bill me? You may receive bills for separate entities associated with your procedure, such as the physician, facility, and/or laboratory. We can only provide you with the information associated with our fees (which includes: Physician, anesthesia and pathology, if processed in house. Pathology is based off your insurance to ensure you receive the best benefit) ****

Listed below is other contact information in relation to the laboratory your specimen(s), if any, may be sent to.
If you are having your procedure at Robert Wood Johnson University Hospital of Somerset, we have included their contact information for your reference as well.

RWJ University Hospital of Somerset
110 Rehill Avenue
Somerville, NJ 08876
(P):908-685-2200

Informed Diagnostics
(Formally known as Miraca Life Sciences)
(P):866-588-3280

Dianon
(LabCorp's pathology division)
(P) 800-845-6167

Digestive Healthcare Center
511 Courtyard Drive
Hillsborough, NJ 08844 (P) 908-218-9222, Ext: 240

FACTS TO KNOW ABOUT MEDICAL DOCUMENTATION, CODING AND INSURANCE

Government and insurance documentation and coding guidelines govern how medical information is captured in your medical record. Medical providers are prohibited by law from altering a patient's medical chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law. Your medical record cannot be changed to facilitate better insurance coverage.

Most insurance carriers will only process a colonoscopy under the preventive benefit for patients **AGE 50** or older with **NO** personal GI history, **NO** family GI history and **NO** current or past GI symptoms.

Your insurance client service representatives may tell you: *"If the provider codes the record with a "screening" or rebills with a "screening" diagnosis it would be covered at 100%."*

Insurance representatives do not know your medical and family history and are not trained medical records coders. **Be sure to keep notes with the name of the representative you spoke with, date, time and reference number. Always ask for reference #** as this will help with any follow-up questions that may arise.

BE INFORMED: CALL YOUR INSURANCE COMPANY TO REVIEW YOUR BENEFITS
Know what you will owe under your policy!

You will need to provide your preoperative Procedure code (CPT) and Diagnosis codes (ICD). You may contact our billing department with any questions about this information at 908-218-1616.

Please keep in mind that verification of insurance benefits is NOT a guarantee of payment. **Ultimately it is the terms of your insurance policy that will determine your coverage. Be sure you understand your plan benefits.**

****Insurance benefits and healthcare cost estimates are available to you upon request. Please call Digestive Healthcare Center Billing Department at (908) 218-1616 if you prefer for Digestive Healthcare Center to obtain this information on your behalf****

QUESTIONS TO ASK FOR COLONOSCOPY

1. With these diagnosis codes how will my procedure be covered under my policy?
   - **preventative (routine or wellness screening)**
   - **diagnostic (medically necessary)**

2. If there are biopsies taken during my Screening Colonoscopy, will this turn my Screening Colonoscopy into a medical procedure?

3. If processed under my medical benefit what will my deductible and coinsurance responsibility be?

   Deductible:_______________________________ Amount of Deductible Met: ____________

   Family Deductible Met if Applicable: ______________ Coinsurance/Co-pay: ________________

4. Is the Facility where I am scheduled for my procedure in Network? (Benefits change if out of network)

5. For preventative/screening/routine colonoscopy, are there age and/or frequency limits for my colonoscopy? (One every ten years over the age of 50, one every two years for a personal history of polyps, bleeding, constipation, etc.)?

QUESTIONS TO ASK FOR UPPER ENDOSCOPY

1. Since this procedure will fall under my medical benefit, what will my deductible and coinsurance responsibility be?

   Deductible: _________________________________ Amount of Deductible Met: ______________

   Family Deductible Met if Applicable: _______________ Coinsurance/Co-pay: _________________

2. Is the Facility where I am scheduled for my procedure in Network? (Benefits change if out of network)

Name of Representative: ___________________ Reference#: ____________________ Date: ____________

****If you have questions regarding your financial obligations, please call our Billing Department at 908-218-1616. We would be happy to assist you to understand your financial obligations prior to receiving services****