CAROLINA ENDOSCOPY CENTERS

□ **PINEVILLE**
10520 Park Road, Suite 105
Charlotte, N.C. 28210
Phone: (704) 927-5756

□ **MONROE**
1321 East Sunset Drive
Monroe, N.C. 28112
Phone: (704) 261-1220

□ **UNIVERSITY**
101 East WT Harris Blvd, Ste 3215
Charlotte, N.C. 28262
Phone: (704) 927-4280

□ **HUNTERSVILLE**
16455 Statesville Road, Ste 114
Huntersville, N.C. 28078
Phone: (704) 237-9290

Patient Procedure Instructions

Patient Name: _____ ___DOB:_____Chart # _____

Date of Procedure: _____ Arrival Time: _____

Please read and initial the following important policies

_____ Please complete the paperwork in your packet and bring it with you on the day of your procedure. Please bring identification with your picture on it and your Insurance Card.

_____ A responsible driver MUST accompany you to the Endoscopy Center and must stay at the facility for the duration of your procedure and take you home when you are discharged. **Your procedure will be cancelled if you arrive alone or if the person bringing you cannot stay at the facility for the duration of your procedure.** Plan on being at the center approximately 2-2 ½ hours.

_____ If you asked for an interpreter. The interpreter will meet you at the Endoscopy Center the day of your procedure. There is no additional charge for the interpreter. If you asked for an interpreter and changed your mind please call the Endoscopy Center.

_____ Please make sure that you have received a copy of your preparation (prep) instructions. If you do not completely understand the prep instructions, please call **Colon Prep Center at 800-349-0285.** If you receive prep instruction in the office, please call and speak to the physician scheduler for clarification.

_____ If you need to cancel your procedure, you must call our office three (3) business days prior to the procedure. If unforeseen circumstances arise the morning of the procedure, you must call the endoscopy center phone number listed above. The center opens between 5:30am and 6:00am. **If you do not show up for your procedure and you have not called our office or the endoscopy center you will be charged a $100.00 No Show fee.**

_____ Our Center's policy on **Advance Directives (Living Will)** is: "The Center's policy for limiting advance directives is to always attempt to resuscitate a patient and transfer the patient to the hospital in the event of deterioration." Please see our website for applicable State Laws on Advance Directives.

_____ **Please contact your insurance carrier prior to the procedure. It is your responsibility to verify your benefits and obtain any necessary PCP referral. Our office will check to see if authorization is required.**

_____ **Any co pay and/or outstanding deductible up to $ 500.00 will be collected at the time of your procedure. Patients without insurance coverage will be required to pay $500.00 at the time of scheduling.**

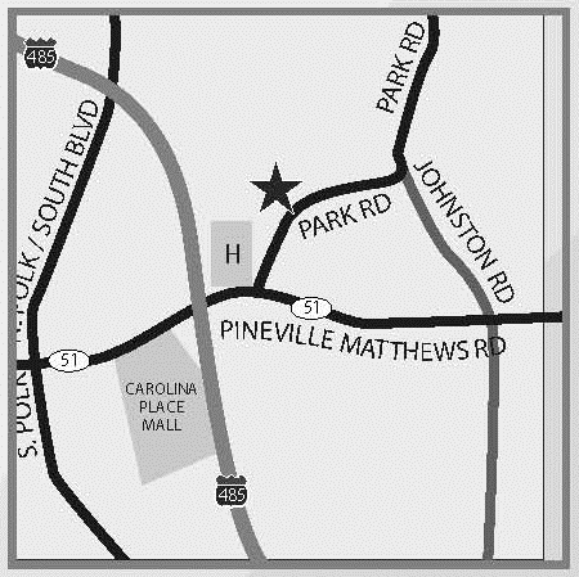
_____ Please do not wear jewelry to the center and please leave all valuables at home. Please do not apply any lotion, skin softeners or perfume, as this interferes with our monitoring equipment. Please dress comfortably and wear comfortable, flat-soled shoes **(AVOID wearing high heeled shoes**).

I have read and understand the policies above.

_____

Patient's Signature Date

Pineville



From the North:

Take I-77 S
Take exit 2 to merge onto I-485 E
Take exit 64A for NC-51 N toward Matthews
Merge onto NC-51 / Pineville-Matthews Rd
Turn left at Park Rd
On left, past 1st light in building with HorizonEye

From the South:

Head North on US-521 N
Turn left to merge onto I-485 / US-521 N
Take exit 64A for NC-51 N
Merge onto NC-51 / Pineville-Matthews Rd
Turn left at Park Rd
On left, past 1st light in building with HorizonEye

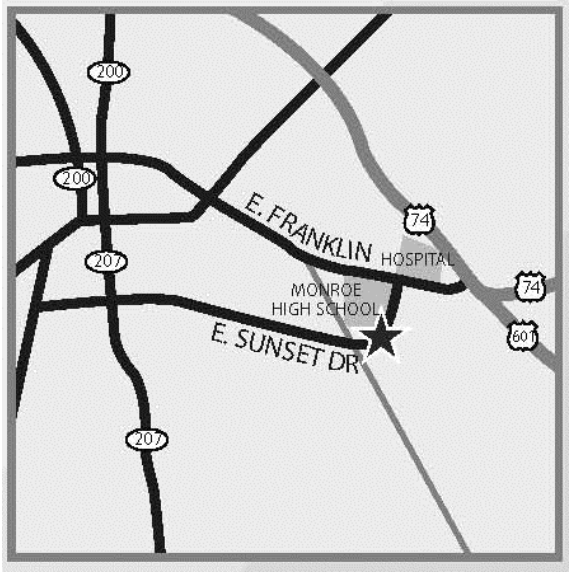
From the East:

Take I-485 W
Take exit 64A for NC-51N
Merge onto NC-51 / Pineville-Matthews Rd
Turn left at Park Rd
On left, past 1st light in building with HorizonEye

From the West:

Take I-485 E
Take exit 64A for NC-51 N toward Matthews
Merge onto NC-51 / Pineville-Matthews Rd
Turn left at Park Rd
On left, past 1st light in building with HorizonEye

Monroe



From the North:

Head South on Concord Hwy / US-601
Turn right onto US-74 E ramp
Merge onto US-74 E
Turn right at E Franklin St
Turn left at E Sunset Dr

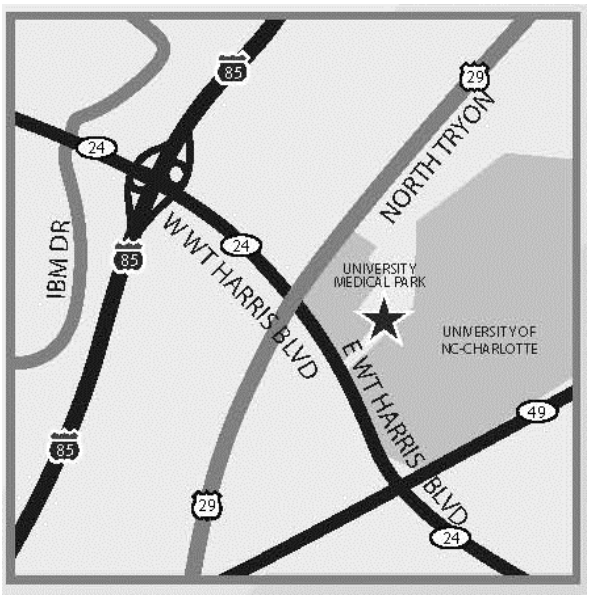
From the West:

Head Northeast on
Waxhaw Hwy / NC-75
Continue on Waxhaw Hwy
Continue on NC-75 / NC-84
Continue on E Franklin St
Turn right at E Sunset Dr

From the East:

Head West on US-74 W
Turn left at E Franklin St
Turn left at E Sunset Dr

University



From the North:
Take I-85 S toward Charlotte
Take exit 45A for Harris Blvd / NC-24E
Merge onto NC-24 / West WT Harris Blvd
Crossover Hwy 29
University Med Park is on the left
3000 building, 2nd floor

From the South:
Head North on East WT Harris Blvd
Crossover Hwy 49
Turn right at University Medical Park
3000 building, 2nd floor

From the East:
Head SW on NC-49
Turn right on the East WT Harris Blvd ramp
Continue on E WT Harris Blvd
University Medical Park is on the right
3000 building, 2nd floor

From the West:
Take I-85 N
Take exit 45A for Harris Blvd NC / NC-24E
Merge toward NC-24E / East WT Harris Blvd
Crossover Hwy 29, University Medical Park is on the left
3000 building, 2nd floor

Huntersville

From the North:
Head South on I-77
Take exit 25 for NC-73 toward Huntersville
Turn left at NC-73 E / Sam Furr Rd
Turn right at Statesville Rd / US-21
Turn right into CMC-Huntersville

From the South:
Head North on I-77
Take exit 25 for NC-73 toward Huntersville
Turn right at NC-73 E / Sam Furr Rd
Turn right at Statesville Rd / US-21
Turn right into CMC -Huntersville

From the East:
Head West on Davidson
Hwy / NC-73
Continue to follow NC-73
Turn left at Statesville Rd / US-21
Turn right into CMC-Huntersville

From the West:
Head East on NC-73
Turn right at Statesville Rd / US-21
Turn right into CMC-Huntersville

CAROLINA ENDOSCOPY CENTERS
PATIENT RIGHTS

Patient will be accorded impartial access to available medical treatments regardless of race, creed, national origin, religion, sex, age, or handicap.
Patient is entitled to information regarding his/her rights at the earliest possible time in course of treatment.
Patient will have access to an interpreter when necessary and at earliest possible time.
Patient has the right to quality care by competent individuals adhering to high professional standards.
Patient has the right to inquire and be informed of providers' qualifications and credentialing criteria.
Patient has the right to change their provider if other qualified providers are available.
Patient will receive respectful care that at all times is considerate of his/her personal dignity.
Patient is entitled to personal privacy in treatment and in caring for personal needs.
Patient has the right to be free from of harassment, neglect and abuse from staff, other patients and visitors.
Patient is entitled to confidential treatment of his/her medical records and must consent to their release except when required by law.
Patient is entitled to care that avoids unnecessary discomfort and pain.
Patient has right to be free from seclusion and restraints in accordance with Center policies.
Patient is entitled to be involved in his/her discharge planning and to receive information concerning his/her continuing healthcare needs and the means for meeting them, as well as the alternatives.
Patient is entitled to refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal, including the right to refuse to participate in experimental research.
Patient has the right to expect reasonable continuity of care when appropriate and to be informed of available options when care is no longer appropriate or when transfer to another facility is necessary.
Patient is entitled to have emergency procedures implemented without delay.
Patient and/or authorized representative has the right to participate in decisions involving his/her health care, including diagnosis, evaluation, treatment and prognosis.
Patient shall not be subjected to non-emergency treatment, procedure, research or other programs without his/her voluntary and competent consent or the consent of legally authorized representative.
Patient is entitled to receive information about Center rules and regulations affecting patient care and conduct including procedure for handling of patient complaints.
Patient is entitled to receive an itemized and detailed explanation of bill for services provided.
Patient has the right to access protective services and patient's legally authorized representative may exercise rights on behalf of patient.

CAROLINA ENDOSCOPY CENTERS
ADVANCE DIRECTIVES POLICY

Notice of limitation: An attempt to resuscitate and transfer to a hospital in the event of deterioration will occur.

_____ _____
(**Patient's Signature**) (**Date**)

CAROLINA ENDOSCOPY CENTERS
PATIENT RESPONSIBILITIES

Patient is responsible for providing accurate and complete information about his/her health including current complaints, past illnesses, hospitalizations, past and current medications including over the counter products and dietary supplements, any allergies and sensitivities and any other relevant information.
Patient is responsible for providing a responsible party to remain at the Center during his/her stay and to transport him/her home from the facility.
Patient and his/her representatives are responsible for reporting obvious risks regarding his/her care and any changes in patient's condition.
Patient, or patient representative, is responsible for expressing patient wishes and needs so appropriate care can be provided.
Patient is responsible for asking questions when they do not understand what they have been told about their care and what is expected of him/her.
Patient is responsible for clearly stating his/her concerns, worries and fears regarding handling of their follow-up care and treatment.
Patient and family are responsible for following the treatment plan as prescribed by the provider and participating in his/her care.
Patient and family are responsible for the outcomes of not following care and treatment plan.
Patient and family are expected to be considerate to the Centers' personnel and property.
Patient and family are expected to be kind to other patients and their families.
Patient and family are expected to follow the Centers' rules and regulations regarding patient care and conduct.
Patient and family are expected to behave in an appropriate manner at all times.
Patient and family are responsible for behavior that may place the health and well being of others at risk.
Patient is responsible for providing the Center's administration staff with accurate and timely information about his/her ability to pay for services.
Patient is responsible for promptly paying for services, including charges not covered by his/her insurance.
Patient is responsible for providing information about any living will, medical power of attorney or other directive that could affect his/her care.

If you have a question about your care or the safety of your surroundings, please let us know. If at any time you have a complaint or concern, you may contact your nurse, the charge nurse or **the Director**. You can expect the Endoscopy Center to respond in a timely manner. Although it is our desire to resolve your concerns at the local level, it is your right to make a complaint directly to the Accreditation Association for Ambulatory Health Care (AAAHC) or the NC Department of Health and Human Services (State Survey Agency) as follows:

Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2712 Mail Service Center, Raleigh, NC 27699-2712
1-800-624-3004 (Toll-free)
State Representative-Rita Horton
Web site: www.facility-services.state.nc.us
Visit the Ombudsmans's webpage at:
www.cms.hhs.gov/center/ombudsman.asp

AAAHC
5250 Old Orchard Road
Suite 200
Skokie, Ill. 60077
847-853-6060
www.aaahc.org

_____ _____
(**Patient's Signature**) (**Date**)

Carolina Endoscopy Centers

Patient Financial Responsibility Agreement

In order for Carolina Endoscopy Center to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENTS' RESPONSIBILITY.

As a patient of Carolina Endoscopy Center, you are hereby agreeing:

- To pay all non-insured charges, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised.

- To provide us with a copy of your current insurance card or other Proof of insurance at the time of EACH service, including hospital-based services. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.

- To obtain any required authorization under your insurance plan for our services from your primary care physician and/or your insurer prior to each appointment.
  If you do not receive the required authorization, your insurer may not pay us for our services. In these cases, you agree to personally pay any resulting unpaid charges.

- ***To Monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding non-payment, and to cooperate with CDHA to resolve the unpaid status of your account.

- We charge a fee to patients that do not arrive for their appointment or do not provide adequate notice.
  $100.00 Endoscopy Center

Further, you agree that your physician and Carolina Endoscopy Center has the right to be paid for their services and you acknowledge:

- **That unpaid bills older than 60 days from date of service may be turned over to a debt collection agency or attorney for collection.**

- **That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.**

By my signature, I am indicating that I have read, understand and agree to the above provisions.

_____ _____

Patient or Guarantor Signature **Date**

For your information, please be informed that Carolina Digestive Health Associates, P.A. (CDHA) has a significant ownership interest in Carolina Endoscopy Centers and accordingly, the physician-shareholders of CDHA are indirect owners of the endoscopy center.

Carolina Endoscopy Centers

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

Sex

☐ Male ☐ Female ☐ Other

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Unknown ☐ Patient declines to specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Vietnamese ☐ Patient declines to specify Other:_____

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call - Home ☐ Patient declines to specify

Other:_____

Pharmacy

Name Address Phone

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies
- [ ] Latex
- [ ] Penicillins
- [ ] aspirin
- [ ] Iodine-Iodine Containing
- [ ] Sulfa (Sulfonamide Antibiotics)
- [ ] Codeine
- Other: _____
- Other: _____
- Other: _____
- Other: _____

Current Medications

- [ ] None

Name	Dose	How taken?

Past or Present Medical Conditions

- [ ] None

- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Asthma / Bronchitis
- [ ] Bleeding problems
- [ ] Colon cancer
- [ ] COPD / Emphysema
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Fibrositis / Fibromyalgia
- [ ] Gallstones
- [ ] Glaucoma
- [ ] Heart disease
- [ ] Heart Murmurs
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High blood pressure
- [ ] Colon polyp history
- [ ] HIV
- [ ] Irritable Bowel Syndrome
- [ ] Kidney disease
- [ ] Parkinson's Disease
- [ ] Reflux Disease (GERD)
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Ulcer Disease
- [ ] Stroke
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Ulcerative Colitis
- [ ] Defibrillator
- Other: _____

Other: _____ Other: _____

Previous Procedures

- [ ] None

- [ ] Defibrillator Placement
- [ ] Pacemaker Insertion
- Other: _____

When: _____ When: _____

Immunizations

- [ ] None

- [ ] Flu vaccine
- [ ] Pneumonia vaccine
- Other: _____

When: _____ When: _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Abdominal Ultrasound
- [ ] EGD
- [ ] Colonoscopy
- [ ] Flexible Sigmoidoscopy
- [ ] CT Abdomen

When: _____ When: _____ When: _____ When: _____

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None

- [ ] Type spirits

Quantity _____ Number _____ Frequency _____

Caffeine

- [ ] None

caffeine Intake:_____

Tobacco

Smoking Status

Current every day smoker | Current some day smoker | Former smoker | Never smoker

Smoker, current status unknown | Light tobacco smoker | Heavy tobacco smoker | Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Drug Use

None

Type	Quantity	Number	Frequency
Marijuana			
Cocaine			
IV Drugs			

Family Medical History

No knowledge of family history

No family history of

Celiac sprue | Colon cancer

Colon polyps | Liver disease

Ulcerative Colitis / IBD

Health Status	Father	Mother	Brother	Sister
Deceased/At Age	____	____	____	____
Cause of Death	_____	_____	_____	_____
Diagnoses				
History of colon cancer				
History of colon polyps				
Crohn's disease, colon				
Diabetes mellitus (Type I)				
Diabetes mellitus (Type II)				
Gallstones				
Pancreatitis				
Ulcer, gastric				
Ulcerative colitis				
Other:				
Other:				

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
Shortness of Breath	○	○
Swelling of Ankles	○	○
Pacemaker	○	○
Defibrillator	○	○
Stents	○	○

Constitutional

None	Y	N
Feeling Tired	○	○
fever	○	○
sweats/chills	○	○
weight gain	○	○
weight loss	○	○
Pregnant	○	○
Jaundice	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
nose bleeds	○	○
sore throat	○	○
Hearing Aid	○	○
Hoarseness	○	○
Sinus Problems	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
Blurred Vision	○	○
Glaucoma	○	○
Contacts or Glasses	○	○

Genitourinary

None	Y	N
frequent urination	○	○
Blood in Urine	○	○
Incontinence	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
heartburn	○	○
nausea	○	○
vomiting	○	○
Anal Itching	○	○
Anal Pain/Sore	○	○
Appetite loss	○	○
Belching	○	○
Bloating	○	○
Difficulty Swallowing	○	○
Get full easily	○	○
Incontinence of Stool	○	○
Pain on Swallowing	○	○
Pain when Defecating	○	○
Black / Tarry Stool	○	○
Maroon Stool	○	○
Rectal Bleeding	○	○
Vomiting Blood	○	○
"Coffee Grounds"	○	○

Hematologic/Lymphatic

None	Y	N
Anemia	○	○
easy bleeding/bruising	○	○
past blood transfusion	○	○

Integumentary

None	Y	N
itching	○	○
skin ulcers	○	○
rashes	○	○

Musculoskeletal

None	Y	N
Back pain	○	○
Joint pain	○	○
Muscle Pain	○	○
Joint Replacements	○	○
Joint Swelling	○	○

Neurological

None	Y	N
fainting	○	○
frequent headaches	○	○
seizures	○	○
Brain/Spinal Injury	○	○
Confused	○	○
Weakness/Numbness	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○

Respiratory

None	Y	N
Chronic cough	○	○
Sleep Apnea	○	○
Use of C-PAP	○	○
Difficulty opening Mouth	○	○
Positive TB skin test	○	○
wheezing	○	○
DifficultyTurning head	○	○
Use of Oxygen @ Home	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

Signature Date