CAROLINA ENDOSCOPY CENTERS

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

Δ **MONROE**
1663 Campus Park Dr, Ste A
Monroe, N.C. 28112
Phone: (704) 261-1220

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

Δ **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 accommodate interpreting needs by providing language line interpreter service during your procedure.

_____ 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.**

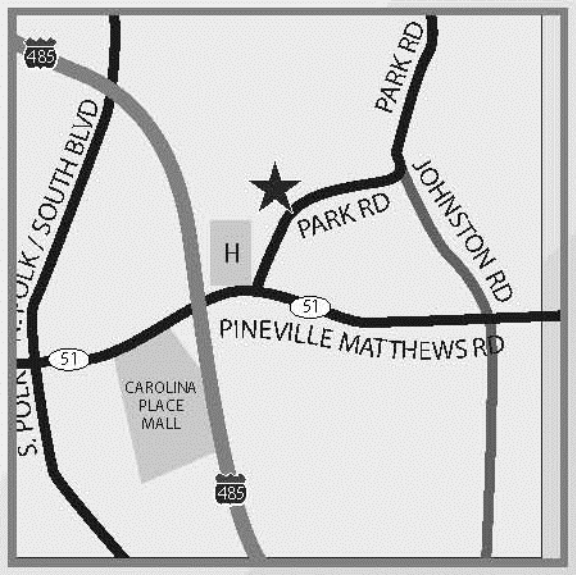
_____ Please do not wear jewelry to the center and please leave all valuables at home. Please do not apply any lotion, skin softeners or perfume, as this interferes with our monitoring equipment. Please dress comfortably and wear comfortable, flat-soled shoes **(AVOID wearing high heeled shoes)**.

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 Exit onto Hwy 74 going east
Turn left onto Campus Park Dr at intersection of Hwy 74 and Hwy 601

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 onto Hwy 74
Turn left onto Campus Park Dr at intersection of Hwy 74 and Hwy 601

From the East:

Head West on US-74 W
Turn right onto Campus Park Dr at intersection of Hwy 74 and Hwy 601

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
2000 building, 2nd floor

From the South:
Head North on East WT Harris Blvd
Crossover Hwy 49
Turn right at University Medical Park
2000 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
2000 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
2000 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**)

FINANCIAL INFORMATION

Thank you for choosing Carolina Endoscopy Centers for your Gastroenterology services. We are committed to providing compassionate high-quality healthcare. We value you as a patient and look forward to serving your healthcare needs. Please understand that a sound financial policy is part of every practice. The following is a statement of our financial policy.

Fees, Payments, and Patient Responsibility

Our fees are based upon the reasonable and customary charges prevailing in this area and consider the complexity of a problem. Payments for office visits and office-based procedures are expected at the time of your appointment. You may pay with cash, check, or any major credit card. We will collect these fees at the time of registration, prior to seeing the physician.
For self-pay patients (if patient plans to pay without the use of insurance) or if patient does not have an insurance card at the time of registration, we require full payment at the time of service with a minimum fee of $500.00 towards the anticipated services. Additional fees may be assessed later.

For planned procedures, we will contact patient's insurance company to verify benefits, deductible, and co-insurance amounts. A pre-procedure deposit may be required based on these benefits or the patient's insurance status.

In addition, if you should need assistance with your deductible / co-insurance, Care Credit is a program, that if you qualify, will assist you in paying for your healthcare needs. Care Credit will make the payment for your services and then set up a monthly payment schedule with you.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service.

- **Payments:** Unless other arrangements are approved by CDHA in writing, the balance on your statement is due and payable when the statement is issued and is past due if payment is not received within 30 days.
- **Automatic Payment Plan:** The Automatic Payment Plan is a convenient way for you to make your monthly payment by using your credit card.

Past Due Accounts: If patient account becomes past due, we will take necessary steps to collect this debt. If we have to refer past due balances to a collection agency and/or a lawyer, collection costs incurred will become the responsibility of the patient.

Insurance

To process claims on your behalf, we must have your complete personal information including:

- Legal Name
- Address
- Insurance information (both primary and secondary)
- Employer
- Guarantor information

Please bring your driver's license or another government issued photo ID on your first visit. Insurance information can change frequently. Please bring your current insurance card with you at every visit. We will update and/or confirm the accuracy of this information at each office visit. It is your responsibility to inform us promptly of any changes to your billing information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full.

As participating providers, we follow all mandatory guidelines as specified in each carrier's contract. Upon verification that we participate with your plan, we will file our charges with your carrier. With most participating contracts, we are required to collect the full "allowed" amount. (The "allowed" amount is specified by your carrier.) Patients are responsible to pay co-payment and/or deductible at the time services. Insurance carriers may have provisions in their policies resulting in the denial and nonpayment of specific services. In these cases, the patient, will be responsible for the non- covered charges.

LABORATORY SERVICES

If your insurance requires a specific laboratory, please inform us on or prior to the day of your visit.

Refund Policy

Patients may contact our billing office by calling 704-372-7974 Ext. 2183 for all refund requests. Allow 60-90 days to receive your refund via USPS once requested.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM FORMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CAROLINA ENDOSCOPY CENTERS FOR SERVICES RENDERED.

UNLESS WE PARTICIPATE WITH YOUR INSURANCE, PAYMENT IN FULL IS EXPECTED WHEN SERVICE IS RENDERED. WHETHER OR NOT YOUR INSURANCE COMPANY MAKES PAYMENT, IS A MATTER BETWEEN YOU AND YOUR INSURANCE CARRIER. UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE, ANY UNPAID BALANCES ARE DUE WITHIN 30 DAYS OF TREATMENT. FAILURE TO PAY FOR SERVICES OR ADHERE TO PAYMENT ARRANGEMENTS WILL RESULT IN COLLECTION ACTIVITY. ALL COLLECTION COSTS INCURRED BY CAROLINA ENDOSCOPY CENTERS, INCLUDING ATTORNEY FEES (33.3% OF PRINCIPAL BALANCE) AND INTEREST IN THE AMOUNT OF 1.5% PER MONTH ACCRUING 30 DAYS AFTER YOUR LAST BILLING, WILL BE THE SOLE RESPONSIBILITY OF THE RESPONSIBLE PARTY NAMED HEREIN.
I ACCEPT RESPONISBILITY FOR ANY PATIENT BALANCE.

Carolina Endoscopy Center

Notice of Privacy Practices Acknowledgment

Patient Name _____ **Date of Birth** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Carolina Digestive Health Associates, PA and its affiliates (CDHA) have given me the opportunity to read a detailed notice of their Privacy Practices.

CONSENT TO COMMUNICATE WITH YOU

☐ I authorize CDHA to leave results or protected health information on my voicemail ☐ Home ☐ Cell ☐ Work

While CDHA takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication. **You may use CDHA's Patient Portal to securely communicate electronically with your CDHA provider.**

CONSENT TO COMMUNICATE WITH OTHERS

☐ I **do not** authorize CDHA to communicate health information with anyone other than me, excluding all disclosures allowed by law.

☐ I authorize representatives from CDHA to share information regarding care or test results with the individuals listed below if I cannot be reached. These individuals may also request protect health information on my behalf.

Name _____ **Relationship**_____
Phone_____
Name _____ **Relationship**_____
Phone_____
Name _____ **Relationship**_____
Phone_____

I recognize that CDHA may share my protected health information with other healthcare providers, including sensitive health information such as HIV/AIDs information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

X _____
/Authorized Representative Signature **If patient is a minor (under the age of 18), form must be signed by a parent or legal*

FOR OFFICE USE ONLY

If patient does not sign this form, please provide a reason why the acknowledgement was not obtained and witness.

_____
Reason(s)

_____
Witness/Staff Signature Date

Checking Your Healthcare Insurance Benefits

After scheduling any procedure, we recommend you call your insurance carrier to verify your benefits. **It is your responsibility to determine what your benefits cover.** Please know that Carolina Digestive Health will provide your insurance carrier with all necessary Information for your policy to cover the procedure at the maximum allowed amount.

Procedure	CPT Codes
Colonoscopy (outpatient)	45378-45386 - with and without findings
Colonoscopy (in office BCBS of NC @ Billingsley)	45378-45386 - with and without findings
EGD (outpatient)	43235-43259
EGD (in office BCBS of NC @ Billingsley)	43235-43259
Flex Sig (outpatient)	45330-45345
Flex Sig (in office BCBS of NC @ Billingsley)	45330-45345
	Hospital Procedure (outpatient)

- Screening Colonoscopy: Preventative/Wellness (absence of symptoms and/or history)
- Diagnostic Colonoscopy: Symptoms and/or History exist requiring the procedure

If your doctor finds a polyp or other findings during the procedure, your insurance carrier may no longer consider this a preventative/wellness screening procedure. It may then be considered a diagnostic procedure and your insurance benefits may change. Please verify your benefits for both when calling your insurance company.

You may get up to 4 separate statements for your procedure: (1) the physician's charge from CDHA **(2)** the facility charge from the endoscopy center/hospital **(3)** pathology (if any polyps/biopsies are removed) **(4)** anesthesia services.

On the day of your procedure, you will be given the following choices of anesthesia. (Please verify your benefits with your insurance company prior to your procedure)

- **Moderate/Conscious Sedation-** sedated but able to respond.
- **Deep Sedation (Propofol)-** preferred method due to a much shorter recovery time and less risk of nausea and vomiting. In general, a more rapid return to a normal level of alertness.

Please see below for the vendor contact information, Atrium Anesthesia, American Anesthesiology, PDL Laboratories are outside vendors and are not associated with Carolina Digestive. If you received a bill from one of the outside vendors below, please contact them directly regarding billing questions.

Carolina Endoscopy Centers	Anesthesia	Pathology
Billingsley	Carolina Digestive 704-372-7974	Carolina Digestive 704-372-7974
Pineville/University	Atrium Anesthesia 888-276-1910	Carolina Digestive 704-372-7974
Monroe	Carolina Digestive 704-372-7974	Carolina Digestive 704-372-7974
Huntersville	American Anesthesiology 888·280-9533	Carolina Digestive 704-372-7974

Patient MRN: _____

Please Initial the following line, stating we provided you with the above information: _____

Patient Name: _____
Date of Birth: _____

I consent to obtain a history of my medications purchased at Pharmacies
Yes □ No □

I consent to have my medical and demographic information shared with other healthcare entities
Yes □ No □

This form has been reviewed in its entirety with:
Patient □ Parent □ Guardian □ Not present □

Patient Signature: _____ **Date**: _____

MRN #:_____

Patient Review of Systems

Allergic/ Immunologic None ☐
HIV Exposure Y☐ N☐
Persistent infections Y☐ N☐
Strong allergic reactions or Urticaria Y☐ N☐

Cardiovascular None ☐
Chest pain Y☐ N☐
Irregular heart beat Y☐ N☐
Shortness of breath Y☐ N☐
Swelling of ankles Y☐ N☐
Pacemaker Y☐ N☐
Defibrillator Y☐ N☐
Stents Y☐ N☐

Constitutional None ☐
Feeling tired Y☐ N☐
Fever Y☐ N☐
Sweats/chills Y☐ N☐
Weight gain Y☐ N☐
Weight loss Y☐ N☐
Pregnant Y☐ N☐
Jaundice Y☐ N☐

ENM T None ☐
Difficulty swallowing Y☐ N☐
Nose bleeds Y☐ N☐

Sore throat Y☐ N☐
Hearing aid Y☐ N☐
Hoarseness Y☐ N☐
Sinus problems Y☐ N☐

Endocrine None ☐
Excessive thirst Y☐ N☐
Hair loss Y☐ N☐
Heat intolerance Y☐ N☐

Eyes None ☐
Blurred vision Y☐ N☐
Glaucoma Y☐ N☐
Contacts or glasses Y☐ N☐

Genitourinary None ☐
Frequent urination Y☐ N☐
Blood in urine Y☐ N☐
Incontinence Y☐ N☐

Gastrointestinal None ☐
Abdominal pain Y☐ N☐
Abdominal swelling Y☐ N☐
Change in bowel habit Y☐ N☐
Constipation Y☐ N☐
Diarrhea Y☐ N☐
Heartburn Y☐ N☐
Nausea Y☐ N☐
Vomiting Y☐ N☐
Anal itching Y☐ N☐
Anal pain/sore Y☐ N☐
Appetite loss Y☐ N☐
Belching Y☐ N☐
Bloating Y☐ N☐
Difficulty swallowing Y☐ N☐
Get full easy Y☐ N☐
Incontinence of stool Y☐ N☐
Pain on swallowing Y☐ N☐
Black/ tarry stool Y☐ N☐
Maroon stool Y☐ N☐
Vomiting blood Y☐ N☐
'Coffee Grounds Y☐ N☐
Blood in stool Y☐ N☐

Hematologic/ Lymphatic None ☐
Anemia Y☐ N☐
Easy bleeding/ bruising Y☐ N☐
Past blood transfusion Y☐ N☐

Integumentary (skin) None ☐
Itching Y☐ N☐
Skin Ulcers Y☐ N☐
Rashes Y☐ N☐

Musculoskeletal None ☐
Back pain Y☐ N☐
Joint pain Y☐ N☐
Muscle pain Y☐ N☐
Joint replacements Y☐ N☐
Joint swelling Y☐ N☐

Neurological None ☐
Fainting Y☐ N☐
Frequent headaches Y☐ N☐
Seizures Y☐ N☐
Brain/spinal injury Y☐ N☐
Confused Y☐ N☐
Weakness/numbness Y☐ N☐

Psychiatric None ☐
Anxiety Y☐ N☐
Depression Y☐ N☐

Respiratory None ☐
Chronic Cough Y☐ N☐
Sleep apnea Y☐ N☐
Use of C-PAP Y☐ N☐
Difficulty opening mouth Y☐ N☐
Positive TB skin test Y☐ N☐
Wheezing Y☐ N☐
Difficulty turning Head Y☐ N☐
Use of oxygen at home Y☐ N☐

Patient Name: _____
MRN: _____