Informed Consent for Gastrointestinal Endoscopy

Explanation of Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your health care provider(s) advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures. During the examination, the lining of the appropriate portion of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic analysis. Growths (polyps), if seen, may be removed.

To keep you comfortable during the procedure, your physician or a nurse directed by the physician will administer medication defined as moderate (conscious) sedation. If deemed necessary by your physician, an anesthesiologist will be present to administer sedation.

Brief Description of Endoscopic Procedures

☐ **EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach, and duodenum. If active bleeding is found, treatment may be given to stop bleeding.
☐ **Esophageal Dilation**: Dilating tubes or balloons are used to stretch the esophagus.
☐ **Esophageal Varices or Hemorrhoid Banding**: A rubber band is placed around the varices/hemorrhoid to reduce the flow of blood to the vein, thus preventing further bleeding. Injection of a chemical into the esophageal varices with a small needle through the scope may be warranted to sclerose (harden) the vein to prevent further bleeding.
☐ **Flexible Sigmoidoscopy**: Examination of the anus, rectum and left side of the colon, often to a depth of 60 cm.
☐ **Colonoscopy**: Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis are more prone to complications. Polypectomy (removal of growths called polyps) is performed, if necessary, often by the use of a wire loop with or without electric current.
☐ **Other**: _____

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, complications are possible. You can inquire with the physician before doing the procedure regarding a discussion of risk factors. ***You must ask your physician if you have any unanswered questions about your test. A formal consultation can be arranged if you wish.***

1. **Perforation:** Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required and may necessitate the need for a colostomy; which is a bag on your abdomen that stool would come through. Untreated, this complication could be life threatening.
2. **Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy, dilation or banding. Management of this complication may consist only of careful observation, or may require transfusions, repeat endoscopy to stop the bleeding or possibly a surgical operation. Bleeding can be delayed for a few weeks after an endoscopy.
3. **Medication Reactions:** There are risks involved with the administration of any medicine. These risks may include mild inflammation of the vein at the injection site, nausea/vomiting, allergic reactions, impaired cardiovascular function, increase/decrease in blood pressure, breathing problems, or other complications.
4. **Other Risks:** Rarely, damage can occur to teeth or dental work when instruments are inserted through the mouth; complications from other diseases you may already have; not being able to complete the exam; and the possibility of missing a colon cancer or other lesion; instrument failure and death are extremely rare but remain remote possibilities.

You must inform your physician of all your allergies and medical problems. If you think you may be pregnant or have a major change in your medical/surgical history after your pre-operative appointment, it is your responsibility to call our office.

In the event of a complication related to the procedure, a physician will always be available to help manage the complication; however, neither the physician who performed your procedure nor any member of NWG&E will accept any financial responsibility relative to the care involved in managing the complication. Traveling to remote areas or taking an international flight is discouraged for 2 weeks following the procedure, should bleeding or another complication occur.

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is a safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

I understand that because of the sedation I may not drive or operate machinery, make critical decisions, sign legal documents or consume alcoholic beverages on the procedure day. I understand that if I drive myself home after receiving sedation I will be dismissed from this practice and will need to seek medical care elsewhere. I understand that if I do not have an escort I cannot take a taxi home and must arrange transportation by Right at Home, Home Attendant Care or Specialized WTA. If I arrive at the Center without an escort or approved transportation, my procedure will be cancelled. I consent to the taking and publication (without name or any identifying data) of any photographs made during my procedure to assist in my care, and for use in the advancement of medical education. I am aware that my physician may have a financial interest/ownership in Northwest Endoscopy Center. I have been fully informed of the risks and possible complications of my procedure/anesthesia and have been given the opportunity to ask questions.

I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants or designees may perform such procedures as necessary and desirable in the exercise of his/her professional judgment. I understand the Endoscopy Center <u>does not</u> recognize Advance Directives and will use all measures possible to sustain life. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure.

☐ Alan Chang, MD	☐ Barry Levenson, MD	☐ Gregory Munson, MD	☐ James A. Schoenecker, Jr., MD	☐ Todd Witte, MD
☐ Angela Bradley, MD	☐ Christoph Reitz, MD	☐ Hannah Sheinin, MD	☐ Kelly McCullough, MD	

Physician explaining procedure: _____ M.D.Signature: _____Date: _____ Time: _____

_____
☐ **Patient /** ☐ **Legally Authorized Representative** (check one)

Date:_____ **Time:** _____

_____
☐ **Translator/Relationship to Patient**

Witness of Signature only:_____

Patient Label

Northwest Endoscopy Center, LLC
2930 Squalicum Parkway, #202
Bellingham, WA 98225

Informed Consent for Financial Responsibility

The Center was established to meet the special needs of patients with gastrointestinal complaints or diseases. It is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology - no other medical procedures are performed here. The physicians providing services at our facility are all Gastroenterologists and our clinical staff are trained professionals experienced in caring for our patients.

The mission of the Center is to provide quality care to our patients in a specialized outpatient setting. Each patient will have our utmost careful and personalized attention.

The Center is jointly owned by Physicians Endoscopy, LLC and Northwest Gastroenterology, PLLC. The physicians of Northwest Gastroenterology, PLLC are the sole medical providers of the Center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take time to read the following and discuss any questions you may have with one of our billing representatives.

1. The fee that we charge for our services is intended to cover the cost of operating this facility including equipment, staff, rent, supplies, etc. There will also be a separate charge from the physician for their professional services, as well as from the laboratory for any pathology services. The facility, laboratory and physicians are all separate legal entities providing separate and distinct services.

2. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company(s) specified during the registration process, provided we have the complete name and address of the insurance company, and the subscriber's name, social security number and birth date.

3. All co-payments are due and collected at the time of service as required by the contract between the patient, the insurance company and our center.

4. Some insurance plans require pre-certification, pre-authorization or a written referral. It is the patient's responsibility to understand their insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurance company. We cannot accept responsibility for a disputed claim. If the insurance company denies the claim for any reason or withholds payment, the patient is ultimately responsible for the balance.

5. We recognize that there may be times when full payment is not possible. Patients without insurance are expected to pay a minimum of 50% of the cost at the time of service and a minimum of one-third of the remaining balance over each of the three months following the date of service.

6. If you are having financial difficulty or have questions **please contact our Billing Office at (360) 734-1420 option 3,** to discuss your account. Payments are expected to be paid monthly. Non-payment of accounts after three months may result in referral to an outside collection agency that could impact the patient's credit record.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility and that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the Center.

Patient Name: _____ Patient Signature: _____ Date: _____

Center Representative: _____ Date: _____

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Please read the following information on how your insurance company will be billed for your colonoscopy.
This information does not pertain to those of you who have Medicare or Medicare Advantage Plans.

Even if your colonoscopy has been scheduled as a routine screening procedure, it will only be billed as a routine screening procedure if the exam has only normal findings. If there are any unusual findings, such as polyps or abnormal tissue leading to tissue removal/sampling, we are required by law to bill the colonoscopy as a diagnostic procedure. This may affect your out-of-pocket cost for the colonoscopy.

If you are having symptoms or if you have had a colonoscopy in the past for medical concerns, such as personal or family history of colon polyps or colon cancer, Crohn's disease, etc., your current procedure may not be considered a routine screening colonoscopy by your insurance company.

Due to the large number of insurance companies and policies, we are unable to determine your individual insurance benefits. We strongly encourage you to contact your carrier if you have questions regarding your plan and coverage. Our office will obtain a precertification if it is required, but this is not a guarantee of payment.

I have read the above information.

Patient Signature: _____ Date: _____

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I have received verbal and written information, in a language I understand, or that has been translated for me, and have been given the opportunity to ask questions about:

Please initial: _____ Patient Rights & Responsibilities _____ Advanced Directives _____ Physician Ownership Disclosure

Center Representative: _____ Date: _____