



INFORMATION ABOUT YOUR ENDOSCOPIC PROCEDURES

Your doctor has recommended that you undergo a gastrointestinal endoscopy procedure: A gastrointestinal endoscopy involves the direct visualization of part of your digestive tract with a lighted instrument (endoscope). During the endoscopy, the doctor may perform a biopsy (sampling of tissue), a polypectomy (removal of a polyp or growth), removal of a foreign body, injection therapy (instillation of medication through the endoscope), dilatation (expansion of a narrow area), or thermal cautery (application of a heat source to tissue). Endoscopic procedures are generally limited to a particular portion of the digestive tract, based upon each individual patient's condition.

- ☐ **ERCP (Endoscopic Retrograde Cholangio Pancreatography)**- examination of the esophagus, stomach and ducts that drain fluids from the liver, gallbladder and pancreas.

Risks and Possible Complications: The risks of gastrointestinal endoscopy and ERCP include, but are not limited to: pancreatitis, bleeding, infection, perforation (creation of a hole or tear) of tissue, which may require surgical repair, heart or breathing difficulties, and aspiration (passage of stomach contents into your lungs).

Pt. Initials _____ **X**

Alternatives to Gastrointestinal Endoscopy: X-rays, surgery and medication may be used to diagnose and/or treat your digestive tract problem.

Sedation: You will receive sedation during this procedure. The sedation is given through a catheter (tube) inserted into your vein. An anesthesia provider will administer the medications and monitor you throughout the procedure. This medication will relax you, put you to sleep and you should feel no pain. The sedation works quickly and wears off quickly after the procedure. You should not remember the procedure.

Pt. Initials _____ **X**

Risks and Possible Complications: The risks of conscious sedation medications and the use of anesthetic agents administered by an anesthesiologist include, but are not limited to: headache, allergic reaction to the medication or anesthetic agent, nausea, vomiting, aspiration, infection, brain damage, stroke and death.

Pt. Initials _____ **X**

Thank you for scheduling your procedure at our Center. We look forward to taking care of you.

Day of your procedure:

- You **MUST** present valid identification and your insurance cards in order for the Center to perform your procedure according to Federal Trade Commission rules. Valid identification could be: Driver's license or photo identification.
- Your co-payment may be collected on the day of your procedure. You should check with your insurance company as to the amount of your co-pay for a procedure at an out-patient facility. If you have any questions concerning billing or payment policies please contact our billing department at (315) 410-7400.
- You will be given sedation for your procedure and **will not** be allowed to drive yourself home. There is a waiting room for your driver to wait. When you are admitted your driver information will be requested.
- When your procedure is complete, you will be taken to recovery for additional monitoring. Your family member/driver will be requested to be present when the findings of your procedure are discussed. You will also receive written discharge instructions, any prescriptions and educational handouts at this time. They will be reviewed with you and your family before discharge.

General Information:

Hours of Operation: Monday through Friday 7:00 a.m. to 3:30 p.m.

Questions: If you have any questions about your procedure that will be performed at the center, please call us at (315) 410-7400 or 452-3235.

As required by law we make the following disclosures to you in advance of your procedure, along with our patient rights and patient responsibilities:

1. **Advanced Directives:**

In accordance with New York State law, this Center must inform you that we are not required to honor and do not honor DNR directives and will use all measures possible to sustain life. If a patient should provide his/her advance 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. The Center provides information on advanced directives, such as: Health Care Proxy, Do-Not Resuscitate Orders, and Living Wills. If you would like more information regarding advanced directives please call (315) 410-7400. You can also contact the New York State Department of Health for information about Health Care appointing or health care proxy under Article 29-G www.health.state.ny.us/professionals/patients/health_care_proxy/intro.html. This will be reviewed again with you on the day of your procedure.

2. **Ownership Disclosure:**

This is to inform you that your physician might have a financial interest of ownership in the Center. The following are physicians that have a direct ownership interest in our Center: Thomas J. Romano, M.D., Borys Buniak, M.D., and Sara H. Mitchell, M.D.

Patient's Bill of Rights

As a patient of the Digestive Disease Center, you have the right to:

- a. Understand and use these rights. If for any reason you do not understand or you need help, the Center must provide assistance, including an interpreter.
- b. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or source of payment.
- c. Be treated with consideration, respect and dignity including privacy in treatment.
- d. Be informed of the services available at the Center.
- e. Be informed of the provisions of off-hour emergency coverage.
- f. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
- g. Receive an itemized copy of his/her account statement, upon request.
- h. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- i. Receive from his/her physician information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure of treatment or both, the risks involved, and the alternatives for care or treatment, if any.
- j. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
- k. Refuse to participate in experimental research.
- l. Express complaints about the care and services provided and to have the Center investigate such complaints, without fear of reprisal. A patient may express their concern verbally to the Administrator at (315) 410-7400 or in writing. The Center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The Center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the Center's response, the patient may complain to the New York State Department of Health's Office of Health Systems Management by calling 1-800-804-5447. Also, you may contact the Office of the Medicare Beneficiary Ombudsman through the website:
<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>
- m. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
- n. Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract.
- o. Access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of the Title.

Patient Responsibilities

Patients of the Digestive Disease Center of Central New York, L.L.C. seeking treatment at the ambulatory surgery center have the responsibility to:

1. Behave in a responsible manner and observe all center rules and regulations.
2. Treat staff and other patients with courtesy and respect.
3. Be considerate of other patients' rights to confidential care.
4. Provide to the best of your knowledge, accurate and complete information about present complaints, past illnesses, medications and other pertinent facts relating to your health status. A patient is responsible for making it known whether you clearly comprehend a contemplated course of action and what is expected of you.
5. Participate in the decision-making involved in your procedure and follow-up care. This includes being honest on the recovery process and answering questions honestly at discharge, so patients are not discharged prematurely.
6. Discuss with the medical staff any problems or obstacles that may affect your ability to return home for recovery.
7. Be responsible for your actions if you refuse treatment or do not follow instructions.
8. Pay for care on a timely basis after receiving a bill for payment from the Surgery Center.
9. Make suggestions about improving Center operations. Ask questions about any aspect of your care and treatment plan.
10. Participate in the post-procedure telephone survey and patient survey to assist in maintaining high-quality care at the Center.
11. Provide a responsible adult to transport you home from the Center and to stay with you for 24 hours if required by your provider.

I acknowledge that my procedure has been scheduled at the Digestive Disease Center and that the following information was reviewed verbally and copies were given to me.

1. Advanced Directives.
2. Patient Rights and Responsibilities.
3. Physician Ownership in the Center.
- 4. Need to have a family member/friend stay with me and drive me home after the procedure.**
5. Need to bring identification and my co-payment with me the day of the procedure.
6. Please be aware you may be receiving a bill for the anesthesia, a bill from the physician performing your procedure, a bill from the ambulatory surgery center (Digestive Disease Center of Central New York), and possibly a bill for pathology (tissue samples, polyps, etc.). All is subject to your contract with your insurance carrier.

Signature

Print Name

Date of Birth .

Date Form Signed