Procedure Performed At:
Northern NJ Endoscopy Surgical Center
18 Church St, Newton, NJ 07860
Phone: (973) 940-1110

DATE: _____ **TIME:** _____ **ARRIVAL:** _____

Colonoscopy preparation with MiraLAX/Gatorade

- **Before you begin:** **Purchase MiraLAX 238g (8.3 oz.), Dulcolax Laxative 4 tablets (OTC), and two 32 oz. bottles of Gatorade- NO RED, ORANGE OR PURPLE**

- **One Week prior to the procedure:** Stop all supplements (including iron, multivitamins, and fish oil) and blood thinners. These medications include Aspirin or Aspirin-like products (Aleve, Naprosyn, Advil, Motrin and Ibuprofen, Plavix, Coumadin and Percodan). **Tylenol/Acetaminophen** is safe to take prior to procedure. If you are a diabetic, please inform the doctor of any medication you are on or if you are insulin dependent. You may continue your regular medications unless instructed otherwise.

- **On the day before the procedure: NO SOLID FOOD ALL DAY.** Do not have dairy products or juices with pulp. Examples of clear liquids include water, soda, ginger ale, black coffee or tea, juices, clear soup, broth and Jell-O. Do not drink anything red, purple, or orange in color. **It is important to drink as much clear liquids as you can to flush the bowels out and to prevent dehydration.**

- **If you are a diabetic, you may take half of your diabetes medication the day of procedure.**

- **AT 5PM the night before the Procedure:** Divide the 238g of MiraLAX evenly between the two bottles of Gatorade. Stir until completely dissolved. Drink 8 oz. every 10 minutes until it is gone. If you develop cramping, nausea, or bloating you should stop drinking preparation for 30 minutes. Then you can resume drinking the solution. It may take 1-2 hours before you get diarrhea and it will continue for several hours after completely drinking the preparation.
- **30 minutes after drinking the preparation take the 4 tablets of Dulcolax Laxative with water. Continue clear liquids until 6 hours before the procedure and then you must STOP ALL LIQUIDS.**

***If you have any question or concerns do not hesitate to call us at 908-684-3000.**
****Please arrange for someone to accompany you. You will be given sedating medication and will not be allowed to go home on your own.**

*****NOTE:** FAILURE TO TAKE THE PREP AS DIRECTED WILL RESULT IN INCOMPLETE CLEANSING AND MAY REQUIRE CANCELLATION OF THE PROCEDURE OR REPEATING THE PROCEDURE.
Follow Up in office 2 weeks after Procedure

THE FOLLOWING MEDICATIONS NEED TO BE STOPPED PRIOR TO YOUR PROCEDURE

DIABETES / WEIGHT CONTROL MEDS

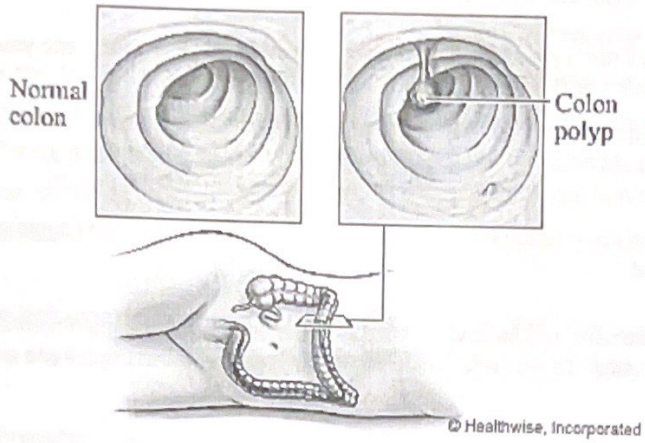
GLP-1 AGONISTS:

EXANATIDE (2 X DAILY)	BYETTA	HOLD 1 DAY PRIOR
EXANATIDE ER	BYDURION	HOLD 1 DAY PRIOR
LIXENATIDE (DAILY)	ADLYXIN	HOLD 1 DAY PRIOR
LIRAGLUTIDE (DAILY)	VIKTOZA, SAXENDA	HOLD 1 DAY PRIOR
SEMAGLUTIDE (DAILY)	RYBELSUS	HOLD 1 DAY PRIOR
DULAGLUTIDE (WEEKLY)	TRULICITY	HOLD 1 WEEK PRIOR
SEMAGLUTIDE (WEEKLY)	OZEMPIC, WEGOVY	HOLD 1 WEEK PRIOR

SGLT-2 AGENTS:

DAPAGLIFOZIN	FARXIGA	HOLD 4 DAYS PRIOR
BEXAGLIFOZIN	BREZAVVY	HOLD 4 DAYS PRIOR
CANAGLIFOZIN	INVOKANA	HOLD 4 DAYS PRIOR
EMPAGLIFOZIN	JARDIANCE	HOLD 4 DAYS PRIOR
ERTUGLIFOZIN	STEGLATRO	HOLD 4 DAYS PRIOR

Learning About Colonoscopy



What is a colonoscopy?

A colonoscopy is a test (also called a procedure) that lets a doctor look inside your large intestine. The doctor uses a thin, lighted tube called a colonoscope. The doctor uses it to look for small growths called polyps, colon or rectal cancer (colorectal cancer), or other problems like bleeding.

During the procedure, the doctor can take samples of tissue. The samples can then be checked for cancer or other conditions. The doctor can also take out polyps.

How is a colonoscopy done?

This procedure is done in a doctor's office or a clinic or hospital. You will get medicine to help you relax and not feel pain. Some people find that they don't remember having the test because of the medicine.

The doctor gently moves the colonoscope, or scope, through the colon. The scope is also a small video camera. It lets the doctor see the colon and take pictures.

How do you prepare for the procedure?

You need to clean out your colon before the procedure so the doctor can see your colon. This depends on which "colon prep" your doctor recommends.

To clean out your colon, you'll do a "colon prep" before the test. This means you stop eating solid foods and drink only clear liquids. You can have water, tea, coffee, clear juices, clear broths, flavored ice pops, and gelatin (such as Jell-O). Do not drink anything red or purple.

The day or night before the procedure, you drink a large amount of a special liquid. This causes loose, frequent stools. You will go to the bathroom a lot. Your doctor may have you drink part of the liquid the evening before and the rest on the day of the test. It's very important to drink all of the liquid. If you have problems drinking it, call your doctor.

Arrange to have someone take you home after the test.

What can you expect after a colonoscopy?

Your doctor will tell you when you can eat and do your usual activities.

Drink a lot of fluid after the test to replace the fluids you may have lost during the colon prep. But don't drink alcohol.

Your doctor will talk to you about when you'll need your next colonoscopy. The results of your test and your risk for colorectal cancer will help your doctor decide how often you need to be checked.

After the test, you may be bloated or have gas pains. You may need to pass gas. If a biopsy was done or a polyp was removed, you may have streaks of blood in your stool (feces) for a few days. Check with your doctor to see when it is safe to take aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs) again.

Problems such as heavy rectal bleeding may not occur until several weeks after the test. This isn't common. But it can happen after polyps are removed.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

Where can you learn more?

Go to https://www.healthwise.net/PatientEd

Enter **Z368** in the search box to learn more about **"Learning About Colonoscopy".**

Northern NJ Endoscopy Center
18 Church St.
Newton, NJ 07860
Tel: 973-940-1110
Fax: 973-940-1109

Thank you for choosing Northern NJ Endoscopy Center for your upcoming procedure. Our staff looks forward to providing you with state-of-the-art medical care with an emphasis on patient safety and comfort.
The Center is accredited by the American Association of Accreditation of Ambulatory Surgical Facilities. It is our mission, along with AAAASF, to develop and implement standards of excellence to ensure the highest quality of patient safety. This facility has been inspected and has met 100% of the standards set by AAAASF.

Please look over the following information provided to help prepare for your visit. If you have any questions about the facility or your procedure please feel free to call at **973-940-1110.** Our staff is available to help you.

Pre-Procedure Call:
A day or two before your procedure you will receive a call from the Center by one of the nurses. The nurse will ask questions about your medical history, allergies and any medications you may be currently taking. Your time of arrival will also be confirmed as schedule changes may sometimes become necessary. You will be asked if you have an Advanced Directive or Living Will. It is not the policy of the Center to acknowledge Advance Directives. If you would like more information on Advance Directives we will be happy to provide you with a packet.

Day Before Your Procedure:
FOR EGD: Nothing by mouth after midnight
FOR COLONOSCOPY: Your doctor will instruct you about what preparation to be used before your colonoscopy. If you have any questions about this prep, please feel free to call your GI doctor.
FOR BOTH EGD AND COLONOSCOPY: Your doctor will instruct you about holding certain medications, such as aspirin, coumadin or plavix. Please make sure you ask your doctor.
If you are taking medications for your heart, blood pressure or seizures, we recommend you continue to take them as scheduled including the day of your procedure. These medications may be taken with a few small sips of water up to three hours before your appointment. **Please refrain from chewing gum for a minimum of 3 hours prior to arrival.**
If you are taking diabetes medications please consult with your doctor.

What to Wear and Bring:
Wear comfortable, casual clothing. Leave all valuables at home. We are not responsible for any losses. Glasses and dentures may be removed before your procedure and placed with your belongings.
You will need to have a **photo ID, insurance information and a driver who is 18 Years of age or older.**

* ***You may NOT walk home or use public transit such as a bus or train even if accompanied by a responsible adult.****Although your driver is not required to remain at the facility for the duration of your stay, your driver **MUST** sign the Responsible Adult Driver Form. Your driver will be asked to be available so that the physician and nurse can

go over the discharge instructions. You may not go home alone and you can not drive for the next 24 hours. You may not use Uber, Lyft, or private taxi unless you are accompanied by an adult family member or trusted friend. **TO ENSURE PATIENT SAFETY, ALL DRIVERS MUST COME INSIDE THE FACILITY BEFORE YOU ARE DISCHARGED.**

Upon Your Arrival:
Have your paperwork filled out to be given to the receptionist which consists of❶ patient registration form, ❷HIPAA, ❸Authorization to Release Information, and ❹medication list form. (Please include all prescription and over-the-counter medications and supplements you normally take-even the ones you are temporarily holding prior for your procedure.) Failure to complete these forms prior to your visit may result in a delay in the start time of your procedure. A nurse will take you to the pre-op area where they will review your history and medication again. Your vital signs will be recorded and an IV will be started. The anesthesiologist will meet you here and talk to you about your procedure.

Discharge:
You will be in the Center from 1 ½ hours to 2 hours. The procedure itself takes anywhere from 15 to 30 minutes. You will be taken to the recovery area for approximately 30 minutes. When you are fully awake your physician will review the findings with you. We suggest you have your family member or person responsible available for this information.

Ownership:
In order to comply with the law the Center must disclose ownership. Your physician may have ownership in the Center.

Billing:
The Center will bill your insurance for your procedure. Statements will be mailed accordingly if there is a balance. In addition, your insurance company will be billed separately by your physician, anesthesiologist, and if applicable, the laboratory where specimens have been sent.

Location Of Facility on 18 Church Street, Northern New Jersey Endoscopy Center :
When you turn on Church Street, parking lot is directly on your left. You must park in this lot or along the fence. Do not park behind building 14 or 16 as these are private lots for those buildings or they will have you towed. **Do not go to the front of the building, that is not our entrance.** From the parking lot we are the third building along the alleyway. We are on the ground floor facing the parking lot with a green awning above our door which says Northern NJ Endoscopy Center.

Cell Phone Usage
Patients will be required to give their cell phones/electronic devices to the responsible person driving them home before leaving the waiting room. In addition, cell phone/ electronic devices are only to be used in the waiting room by anyone visiting the facility. No cell phone usage is permitted throughout the rest of the facility to protect patient privacy. Absolutely **NO** photography is permitted anywhere in this facility.

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

PATIENT RIGHTS & RESPONSIBILITIES

This accredited facility presents these Patient Rights and Patient Responsibilities to reflect the commitment to providing quality patient care, facilitating dialogue between patients, their physcians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to the patient to advocate foe expanded personal relationships and open communication between patients and their designated support persons, physicians and the organization's staff members. This facility has many functions to perform, including but not limited to, preventing and treating medical conditions, providing education to health professionals and patients, and conducting clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guaranteë that the patient will receive the kind of treatment he or she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

1. The patient has the right to receive considerate and respectful care.

2. The patient has the right to know the name of the physician responsible for coordinating his/her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to, his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person (s) responsible for the procedures and/or treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.

5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternative to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and/or professional relationship that exits between his facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedures or treatment.

8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes engage in or perform human experimentation affection his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following: Confidentiality and discreet conduct during case discussions, consultations, examinations and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physicians regarding continuing health care requirements following discharge. The number to call for all questions or emergency care.

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient ad guest during all phases of treatment.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed and ask question that emerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

Direct any care concerns or complaints to:

The Facility Director: Sarwan S. Kahlam, MD
973-940-1110

Executive Director of AAAASF
Thomas S. Terranova, JD, MAMBA

600 Central Ave, Ste 265
Highland Park, IL 60035
847-775-1970

Office of the Medicare Beneficiary Ombudsman
800-MEDICARE (800-633-4227)
http://QUADA.org

REGISTRATION INFORMATION
(PLEASE PRINT)
PATIENT INFORMATION

DATE _____

PATIENT _____ HOME PHONE (___) _____
LAST NAME FIRST NAME M.I. CELL PHONE (___) _____

RESPONSIBLE PARTY (If minor) _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ EMAIL _____

SEX __M __F ☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED FOR __YEARS

BIRTHDATE _____ AGE _____

SOCIAL SECURITY _____-_____-_____

PURPOSE OF VISIT _____

How did you learn of our practice? _____

EMERGENCY CONTACT _____ EMERGENCY PHONE (____) _____
NAME RELATIONSHIP TO PATIENT

PATIENT EMPLOYER/SCHOOL _____

OCCUPATION _____ EMPLOYER/SCHOOL PHONE (____) _____

SPOUSE (or responsible party) EMPLOYED BY _____ OCCUPATION _____

Business Address _____ Business Phone _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST NAME FIRST NAME M.I

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SSN# _____-_____-_____

ADDRESS (if different from patient) _____ PHONE (____) _____

CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY (PRIMARY) _____

SUBSCRIBER # _____ GROUP # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ___YES ___NO

SUBSCRIBER NAME _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY (SECONDARY) _____

SUBSCRIBER # _____ GROUP # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ (name of insurance company) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative RELATIONSHIP TO PATIENT

Authorization to Release Information and Pay Facility/Anesthesiologist Directly

1. I authorize Northern NJ Endoscopy Center LLC to release to appropriate third parties such information as may be necessary, including diagnosis and other information from my medical records for the purpose of processing my facility and/or anesthesia claims.

2. I authorize all health insurance payments for services rendered to be sent directly to Northern NJ Endoscopy Center LLC and/or Morris Anesthesia Group. These amounts shall not exceed the balance of the Facility and/or Northern NJ Endoscopy Center LLC charges for the services. This is a direct assignment of my insurance policy.

3. I understand that I am financially responsible to Northern NJ Endoscopy Center LLC and/or Morris Anesthesia for all charges not covered by insurance. I understand that I or my insurance company may receive more than on charge originating from different sources for a procedure. For example, separate fees may originate in addition to the physician's fee and will be billed separately (i.e. anesthesiology, facility, and laboratory fees).

4. I acknowledge that the insurance information that I have provided is accurate and true.

5. I understand that in the event of an emergency or the need for extended care, I may be transferred to a hospital or may need to seek Treatment at an Emergency Room within 24 hours after having my procedure performed. In either case, I authorize Northern NJ Endoscopy Center LLC and Morris Anesthesia to obtain a copy of my "Discharge Summary" so as to provide the Center with appropriate follow-up information.

6. I certify that the information given by me in applying under Title XVII of the Social Security Act is correct and I authorize Northern NJ Endoscopy Center LLC and/or Morris Anesthesia to release to the Medicare Bureau, CMS, and/or its intermediaries or carriers any information about me needed for this claim including any medical information relating to my treatment.

7. I understand that I should not bring any valuables to Northern NJ Endoscopy Center LLC, and that the Center is not liable for theft or loss of valuables.

8. Prior to the date of my procedure, I have been informed that the physician who is rendering services has ownership/interest in Northern NJ Endoscopy Center LLC, and I have been offered the option to be treated at another facility. I wish to be treated at the above referenced facility.

9. A copy of the Patient's Rights and Responsibilities has been given to me or to my representative prior to my procedure.

10. A copy of the HIPA A Notice of Privacy for Northern NJ Endoscopy Center LLC has been offered to me or to my representative.

11. I understand that a responsible adult must be present to drive me home from the Center, after my procedure. I also acknowledge that there is a responsible adult whose care I will be under for the next 24 hours.

12. Name of Responsible Person _____Home Phone _____Work Phone _____

13. ADVANCE DIRECTIVES WAIVER: I have previously executed an Advance Directive: YES NO

14. If you answered "YES", read the following important information: If I do not have a previously executed Advance Directive, I acknowledge having been given information regarding this prior to my procedure.

15. Some of the medications used during your procedure could be similar to medications specified in Advance Directives. Therefore to insure the best possible care during your procedure you MUST waive your Advance Directive during admission to the Center.

16. I acknowledge that all resusitative measures will be taken during my stay at the Center, and I further understand that if I have ever signed an Advance Directive, I temporarily waive it in its entirety for the duration of my visit at Northern NJ Endoscopy Center LLC.

17. I further consent to the drawing of blood and testing for exposure to Hepatitis B, Hepatitis C and to the human immunodeficiency viruses in the event that an individual at the Center is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential as specified by law.

By signing here, I agree to all seventeen (17) authorizations on this page.

_____	_____	_____
Patient Signature	Representative	Date
_____	_____	_____
Printed Name	Printed Name	Witness

Notice of Privacy Practices Acknowledgment
Northern NJ Endoscopy Center

18 Church St.
Newton NJ 07860

I understand, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If you have an answering machine may we leave a message Yes or No

With whom may we discuss your procedure information? _____

Patient Name: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason

Northern NJ Endoscopy Center

Patient Medication List

Allergies ☐No ☐Yes If Yes: Drug name/Reaction:_____

_____

Please list All Medications, including: Prescriptions, Over The Counter, Dietary Supplements & Herbal Medications

Medication: ☐No Medications ☐See Attached List	**Dose**	**Frequency**	**Last Dose?**	**Discontinue/Change/ Hold**

☐Resume All Above Medications?

Medication given during procedure: **New Medications to take following this visit:**

Medication	**Dose**	**Frequency**	**New Prescriptions Added**	**Dose**	**Frequency**
Propofol	mg	1X IV			
Lidocaine					
Simethicone					
NormalSaline/ Lactated Ringers					

☐ **No changes in your present medications** ☐**Reviewed with Patient/Guardian & Copy Given**

Nurses Signature:_____ **Date:**_____ **Time:**_____

Patient/Guardian:_____ **Date:**_____ **Time:**_____

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973-940-1110

Executive Director of AAAASF
Thomas S. Terranova, JD, MAMBA

600 Central Ave, Ste 265
Highland Park, IL 60035
847-775-1970

Office of the Medicare Beneficiary Ombudsman
800-MEDICARE (800-633-4227)
http://QUADA.org