LIVE OAK ENDOSCOPY CENTER

Welcome to Live Oak Endoscopy Center
275 18th Street, Suite 101
Vero Beach, FL 32960-5541
772-299-5005

Please read this entire packet carefully. Fill out every page completely. Bring packet with you to procedure.

Thank you for choosing Live Oak Endoscopy Center. Our staff is here to help make your time as pleasant as possible. Here is a brief summary that should help you prepare for the day of your procedure. If you have any questions regarding the procedure, please feel free to contact one of our staff members.

When preparing for your procedure, please be sure to avoid wearing any perfume, cologne, or strong deodorant sprays. We ask this of our patients in order to avid any reactions it may cause to our patients and staff at the facility.

▶ **You MUST have someone drive you home after the procedure.** You will still be under the influence of sedatives, whether you feel it or not. You may resume driving 24 hours after your procedure.

▶ **Please be sure to bring a photo ID and insurance cards with you.** We understand you have already given a copy of them to your doctor's office, but we are a SEPARATE facility and will need to copy them for our records. Our staff will contact you prior to your procedure, if we estimate you will have a financial responsibility with our facility.

▶ **List all medications taken with their dosages that you currently take on the medication record sheet provided.** Due to our liability insurance and JACHO regulations **they must be handwritten. This form is also part of your discharge instructions.**

If you have any questions regarding the procedure or the attached paperwork, please feel free to contact one of our staff members. For questions regarding your prep, please contact your doctor's office.

Live Oak Endoscopy Center, LLC

FINANCIAL POLICIES & INFORMATION

This form is provided to help you understand the facility's policies regarding insurance filing and your financial responsibility to Live Oak endoscopy Center. The facility's services are provided directly to you and not your insurance company. Therefore, you are ultimately responsible for payment of the services rendered. Please read and initial the following statements

_____ **It is YOUR responsibility to know your insurance benefits**. While our staff attempts to obtain your insurance benefits prior to your procedure, the information we receive from your insurance company is not a guarantee of payment. If you question your insurance coverage for your procedure, please call your insurance company directly.

_____ Any financial responsibility quoted prior to the procedure is an **ESTIMATE**. This amount is based on the cost of a basic procedure and could increase if a more involved procedure is performed (ie. if a polyp has to be removed, or an area has to be biopsied). You will be billed after the procedure if the amount collected is less than the amount your insurance company applies to your coinsurance or deductible.

_____ All **ESTIMATED** amounts due will be collected at the time of service unless prior arrangements are made.

_____ **You may receive a total of 3-5 BILLS per date of service. These bills include the facility charges (Live Oak Endoscopy Center), the doctor that performs the services (Dr Lui and Dr. Joseph), the anesthesia provider (Vero Anesthesia), and one or two bills for pathology (Ameripath, ADI, PAIR, or Treasure Coast Pathology depending on your insurance).**

_____ As a courtesy we will bill your insurance. However, if the claim is not paid within 45 days, you will be billed for any balance and **YOU will need to follow-up with your insurance provider**.

_____ If we do not participate with your insurance, the facility fee will need to be paid in full at the time of service. A claim will be filed **once** on your behalf so that you may be reimbursed.

_____ All efforts will be made to collect account balances. Accounts unpaid after 3 bills or 90 days may be turned over to a collection agency. **A collection charge may be added to any outstanding balance and will be your responsibility.**

_____ **A charge of $25 will be applied to your account if a check is returned for non-sufficient funds.**

_____ The patient/guardian will be responsible for any legal fees and/or court costs incurred as a result of failure to pay for services rendered.

I understand the above policies and agree to be responsible for any charges, which are not paid by my insurance company, for the care provided to me while at Live Oak Endoscopy Center.

_____

Patient Signature (Parent/Legal Guardian)/ Date

Patient Sticker

_____

Witness

↓ Left Side Only ↓

PATIENT/NURSING DATA BASE

I have no allergies. ☐ What medication allergies do you have and what happens when you take it? (To Include Adhesives & Latex) _____

Height: _____
Weight: _____

Do you smoke or use tobacco products? ☐ yes ☐ no qty?____
Do you drink alcoholic beverages? ☐ yes ☐ no qty?____
Do you use recreational drugs? ☐ yes ☐ no
Are you resistant to vancomycin? ☐ yes ☐ no
Have you had meds for a staph infection? ☐ yes ☐ no
Who is your Primary Care Doctor? _____

CONDITIONS YOU'VE HAD OR ARE BEING TREATED FOR

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack ____ date
- ☐ Coronary Artery Disease (CAD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Endocarditis
- ☐ Chest Pain
- ☐ Irregular Heart Beat
  - ☐ Atrial Fibrillation
  - ☐ Rapid Heart Rate
- ☐ Defibrillator/ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Anemia
- ☐ Bruising
- ☐ Sleep Apnea - ☐ CPAP Used
- ☐ Asthma ☐ COPD
- ☐ Inhalers ☐ HAVE Them
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Pulmonary Embolism/ DVT
- ☐ Stroke ____ date
- ☐ TIA ____ date
- ☐ Paralysis ____ where
- ☐ Seizures ____ date
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Tremors
- ☐ Thyroid Disease
- ☐ Prostate BPH/Surgery
- ☐ Renal Disease
- ☐ Fluid Restrictions
- ☐ Dialysis ____ days
- ☐ Kidney Stones
- ☐ Diabetes ☐ IDDM ☐ NIDDM
- ☐ Hypoglycemia
- ☐ Arthritis
- ☐ Colon Polyps
- ☐ Hiatal Hernia
- ☐ Ulcer
- ☐ Reflux
- ☐ Rectal Bleed
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Depression/ Anxiety
- ☐ Sleep Disorder
- ☐ Any Limits In Exercise/ Mobility
- ☐ Cancer ____ type

If Pt. did, BS today_____

Have you or any immediate family member experienced any anesthesia complications? ☐ Yes ☐ No If yes, explain below
☐ Sore throat after general anesthesia ☐ Nausea / vomiting
Other / explain: _____

Indicate ALL Previous Surgeries

- ☐ Heart Bypass ____ VESSELS ____ DATE
- ☐ Heart Stents ____ VESSELS ____ DATE
- ☐ Heart Valve Replacement ____ VALVE ____ DATE
- ☐ Pacemaker ____ TYPE ____ LAST CHECKED
- ☐ Defibrillator ____ TYPE ____ LAST CHECKED
- ☐ Carotid Endarterectomy ☐ L ☐ R
- ☐ Abdominal Aortic Aneurysm
- ☐ Lung Resection ☐ L ☐ R
- ☐ Tracheostomy
- ☐ Brain Surgery
- ☐ Organ Transplant _____
- ☐ Cervical/Lumbar Laminectomy/Fusion
- ☐ Total Knee Replacement DATE_____ ☐ L ☐ R
- ☐ Total Hip Replacement DATE_____ ☐ L ☐ R
- ☐ Total Shoulder / Rotator Cuff DATE_____ ☐ L ☐ R
- ☐ Colon Resection ☐ Colostomy
- ☐ Spleenectomy
- ☐ Hysterectomy ☐ Partial ☐ Complete
- ☐ Tubal Ligation-Needs Preg Test
- ☐ Mastectomy ☐ L ☐ R
- ☐ Cesarean Section
- ☐ Prostatectomy ☐ TURP
- ☐ Hernia Repair ☐ L ☐ R ☐ Umbilical
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Gallbladder
- ☐ Cataract ☐ L ☐ R

Please list all surgeries not checked above: _____

Admission Date: Time:

LAST ORAL INTAKE (DATE) (TIME)
(Including prep & medications)

Personal Items: ☐ Glasses ☐ Dentures ☐ Partial ☐ Upper ☐ Lower ☐ Watch
☐ Hearing Aides ☐ L ☐ R ☐ Purse/Wallet ☐ Cell Phone (Turn off)

I have arranged for a responsible adult to drive me home.
Drivers Name _____ Relationship _____
Phone # of ride: _____

PHYSICAL ASSESSMENT

Mobility	Psychological	Neurological	Skin
☐ Independent	☐ Anxious	☐ Alert	☐ Warm
☐ Unsteady	☐ Cooperative	☐ Oriented	☐ Cold
☐ Crutches	☐ Appropriate	☐ Confused	☐ Dry
☐ Cane	☐ Crying	☐ Hard of Hearing	☐ Moist
☐ Walker	☐ Restless	☐ Blind	☐ Pale
☐ Wheel Chair	☐ Hostile		☐ Rash - Make Note
☐ Stretcher			

Prep: ☐ MOVI ☐ OSMO ☐ CITRATE ☐ SUPREP ☐ MIRALAX / DULCOLAX ☐ OTHER

Results: ☐ Liquid ☐ Semi-Liquid ☐ Solid ☐ Clear ☐ Yellow ☐ Brown

See daily monitor log for control #'s and ranges.
BS:_____ Normal Range 80-140 Report < 70 or > 250
Preg. Test: + / - Preg Control + / - HGB:___ PT/INR:___

PRE PROCEDURE TREATMENTS

T _____
BP ___/ ___
P ____ R ___
RA SaO2 ____
Pain Eval.__/10
☐ Note Pain: Where/Intensity

MEDICATIONS ☐ None	Time	Init

☐ 1000cc LR
☐ 500cc LR
☐ 500cc NS
☐ 20g ☐ 22g
#Attempts x___
Site ____Init.___
Make a note on any missed IV's.

① ID Band on Pt. and Verified	
② Verify Consent Correct / Initialed	
③ **Listened & Documented lung sounds for ALL respiratory conditions**	
④ H & P on Chart / Preop Has Reviewed	
⑤ Obtained EKG Strip / Placed on back of Anesthesia Record	
⑥ **Antibiotics for Dr. Lui's pt's. with Heart Valve Replacement, Recent Joint Replacement, or Endocarditis**	

All Staff Notes On Reverse Side

INIT	STAFF SIGNATURE
INIT	STAFF SIGNATURE
INIT	STAFF SIGNATURE

LIVE OAK ENDOSCOPY CENTER
275 18th Street, Ste. 101 • Vero Beach, FL 32960

Pt. Sticker Here

PATIENT/FAMILY TEACHING RECORD

Identification of learning needs, abilities, preferences and readiness to learn.

1. Can patient read/understand English? ____Yes ____No
2. Are cognitive abilities sufficient to learn? ____Yes ____No
3. Is there readiness to learn? ____Yes ____No
4. Is S.O. available for teaching? ____Yes ____No
5. Are there physical barriers to learning? ____Yes ____No
6. Are there cultural/religious beliefs, values or practices to consider? ____Yes ____No
7. Explanation:

Staff Signature _____ Date _____

TAUGHT TO WHOM:	STRATEGIES:	RESPONSE:	EVALUATION:
P Patient F Family O Other D Deferred	V Verbal Explanation W Written Instructions D Demonstration H Handouts	V Voiced Understanding RD Returned Demonstration VP Voiced Partial Understanding N Refused to Learn / Not Responsive	RP Reinforce/Practice NT No Further Teaching Needed

Topics	Taught to Whom	Strategies	Resp.	Eval.	Comments if applicable otherwise write N/A	Staff Signature
Preop Teaching						
Discharge Teaching						

DATE	STAFF NOTES - Date and Time each entry and sign name after written.
	If nurse giving conscious sedation - Place Preop EKG Strip Here. (Sign, Date, Time, Strip, & place Pt. Sticker on it)
	If CRNA giving anesthesia – Place Preop EKG Strip on back of Anesthesia Record. (Sign, Date, Time, Strip, & place Pt. Sticker on it)

POST PROCEDURE FOLLOW-UP CALL

☐ Left message if pt. identified on answering machine - pt. to return call for any questions/concerns: ☐ Doing well / no new complaints per patient / significant other	Instructions Given:

☐ Unable to reach by phone, or unable to identify identity by machine. Follow-up letter mailed on date below.

Staff Signature:	Date:	Time:

MEDICATION RECONCILIATION RECORD

ALLERGIES: Include allergies to medications, foods, latex, etc., and the reaction experienced:

☐ No known drug allergies. _____

_____

MEDICATION	DOSE	Date LAST DOSE TAKEN	DISCHARGE MEDICATION INSTRUCTIONS RESUME OR HOLD MEDS AS NOTED BELOW	
			RESUME	HOLD

Prescriptions given for new medications or refills: _____YES _____NO

1._____

2._____

RECONCILIATION

1. I VERIFY THIS IS A COMPLETE LIST OF MEDICATIONS I TAKE _____
   Patient Signature
2. INSTRUCTIONS ON THE USE OF CURRENT MEDICATIONS AND NEW PRESCRIPTIONS WERE REVIEWED, AND COPY GIVEN TO PATIENT.
3. THE PATIENT ACCEPTS FULL RESPONSIBILITY FOR THE CONTENT AND CONFIDENTIALITY OF THIS RECORD. IT IS RECOMMENDED THAT THE PATIENT KEEP THIS LIST WITH THEM AT ALL TIMES.

Patient/Responsible Person:_____ Nurse:_____ Date:_____

☐ See PACU Record

LIVE OAK ENDOSCOPY CENTER
275 18th Street, Ste. 101 • Vero Beach, FL 32960

Patient Registration Form

Live Oak Endoscopy Center

Last Name	First Name:	Previous Name:
Mailing Address:		Apt#
City/State/ Zip		
Home Phone:	Cell Phone:	WorkPhone:
Preferred Method of Contact for reminder Calls or Messages: Voice ☐ Text ☐		
Family Physician:	Date of Birth:	Sex: Male ☐ Female: ☐
Marital Status:	Social Security#:	
Employer Name:	Emergency Contact:	
Emergency Contact Phone#:	Relationship to Patient:	

Responsible Party- If Patient is a minor(under the age of 18), list the parent or guardian bringing the patient

Last Name:	First Name:	
Date of Birth:	Social Security#:	Phone#:
Address of the Person Responsible:		
City/ State/ Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Can we leave a Call Back message on your phone? Yes / No

Race: ☐ White ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Other ☐ Hispanic ☐ Native Hawaiian/ Pacific Islander	Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic / Latino
Preferred Language: (please select one) ☐ English ☐ Spanish ☐ Indian (Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Other	
Preferred Pharmacy Name & Location:	

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co Name:	Ins. Co Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security#	Policy Holder's Social Security#
Relationship to Policy Holder:	Relationship to Policy Holder:

I have verified that the information above is correct to the best of my knowledge.

Signature of Responsible Party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT - VERSION 4

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protect health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment either directly or indirectly or who may become involved in my care in the future.
- Obtain payment from third-party payers (i.e. Medicare, insurance carriers).
- Conduct normal health care operations such as quality assessments.

I have been informed by the facility of its *Notice of Privacy Practices* containing a more complete description of its uses and discloses of my health information. I have been given the right to review or keep a copy of the facility's *Notice of Privacy Practices* prior to signing this consent. I understand that the facility has the right to change its *Notice of Privacy Practices* at any time and that I may request a copy of the revised notice or view it at www.liveoakendoscopy.com

I authorize my physician and/or facility staff members to discuss my health information with:

(Name) _____ (Relationship) _____

(Name) _____ (Relationship) _____

I understand that I may revoke this authorization in writing and that I may request that you restrict how my protected health information is used or disclosed. I also understand that the facility is not required to agree to the requested restrictions but if they do agree to them, then they are obligated to abide by such restrictions.

I understand that this authorization expires 1 year after the date of signature.

May leave messages at my home phone number ☐ Yes ☐ No

X _____ _____

Patient Signature/Other Responsible Party Date

OFFICE USE ONLY

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

Date:	Signature:	Reason:

LIVE OAK ENDOSCOPY CENTER
275 18th Street, Ste. 101 • Vero Beach, FL 32960