BASS MEDICAL GROUP

Shadelands Advanced Endoscopy Institute, Inc
A Division of BASS Medical Group
498 N. Wiget lane
Walnut Creek, CA 94598
Phone: 925-933-3600 | Fax: 925-933-7900

Dear Patient,

Welcome to Shadelands Advanced Endoscopy Institute. Thank you for choosing us for your procedure and healthcare needs. Our goal is to provide the highest quality care for all of our patients.

Enclosed you will find a registration packet with forms to review and complete. Please take time to fill out the Medication **Reconciliation Form** completely and accurately; please bring the entire packet with you on the day of your procedure. This helps us provide more time during your visit to discuss procedures and management plans. Please review the forms that are provided to you before your procedure. The forms are based on procedural rules and regulations. You will find the following forms in your packet:

- Medication Reconciliation Form
  - Please have the forms complete before arriving at the center. Do NOT sign the form.
- Patient Rights and Responsibilities
  - This form includes information on how to file a complaint or grievance.
- Informed Consents
  - Informed Consent for Anesthesia Services. Do NOT sign the form.
  - Advance Directive form
- Note to patient
  - Please bring ID, insurance card, and paperwork
  - Please leave any valuables including jewelry and cell phones at home, the center is not responsible for any missing items.

Please contact our center at 925-933-3600 if you have additional questions; our nursing staff, administrative staff, and medical directors will be happy to assist you. If our endoscopy center is closed, please contact your doctor's office.

Best regards,

Shadelands Advanced Endoscopy Institute, Inc.

BASS MEDICAL GROUP

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE, INC.

498 N. Wiget Lane Walnut Creek, CA
Phone: (925) 933-3600 Fax: (925) 933-7900

PATIENT INFORMATION SHEET

Patient's Name: _____ Date of Birth: _____ Age: _____ Phone: _____

Sex: Male: ☐ Female: ☐ Street Address: _____ City _____ Zip Code: _____

In case of Emergency: Notify _____ Relationship to Patient: _____ Phone: _____

Name of Insurance: _____ Insurance ID: _____ Effective Date: _____ Subscriber: _____

Name of Insurance: _____ Insurance ID: _____ Effective Date: _____ Subscriber: _____

Please select all that apply. You will receive a follow up call from our facility, please indicate which you prefer.

Contact me by telephone at:

(h) _____ (cell) _____ (w) _____

May leave message at home? Yes: _____ No: _____

with a person other than patient? Yes: _____ No: _____

on cell phone? Yes: _____ No: _____

Procedure Information

Procedure: Colonoscopy EGD SIGMOIDOSCOPY (Flexible) Date of Procedure:

Procedure Duration: 15 minutes 30 minutes 45 minutes Diagnose & ICD CPT: ( ) 43239 ( ) 45385

Physician: R. Sharma C. Mullen C. Wadhwa A. Vaziri M. Hosseini S. Narayan L. Higa H. Cheng N. Salehomoum

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by Shadelands Advanced Endoscopy Institute. Transmittal by Fax is authorized. I hereby assign benefits to Shadelands Advanced Endoscopy Institute. I understand that payment is due as services are provided unless I have authorized insurance billing. **If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately.** In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account I/we agree to pay attorney's fees and court incurred for collection.

Patient's Signature: _____ Date: _____

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE, INC.

498 N. Wiget Lane
Walnut Creek, CA 94598
Tel.: (925) 933- 3600
Tel.: (925) 933- 7900

INFORMED CONSENT

ADMISSION AGREEMENT, AUTHORIZATION FOR AND CONSENT TO DIAGNOSTIC OR THERAPEUTIC PROCEDURES, AND ADMINISTRATION OF ANESTHETICS

Patient name: _____ I authorize and consent to__ DR. R. SHARMA__ DR. C. MULLEN __DR. A. VAZIRI___S. WADHWA___ M. HOSSEINI__S.NARAYAN __H. CHENG __L. HIGA __N.SALEHOMOUM to perform the following procedure(s) marked below and procedural sedation. I also consent to Dr. _____ to provide sedation and anesthesiology care. Explanation of procedure: Endoscopy is the direct visualization of the digestive tract interior linings. The digestive tract is visualized with a lighted flexible tube. During the inspection of the lining, certain diagnostic or therapeutic interventions may be performed. A sample of tissue may be taken (biopsy or brushing). A polyp may be removed (polypectomy). Narrowing or strictures may be stretched or dilated. Pictures will be taken of the digestive tract during the procedure. I consent to the following procedures:

___ Esophagogastroduodenscopy (EGD) with possible dilation*, biopsies, cauterization, photography, polypectomy and procedural sedation**: Examination of the esophagus, stomach and duodenum to look for ulcers, tumors, inflammation and areas of bleeding.
___ Colonoscopy with possible biopsies, cauterization, photography, polypectomy and procedural sedation**: Examination of all or a portion of the colon.
___ Flexible Sigmoidoscopy with possible biopsies, cauterization, photography and polypectomy and possible procedural sedation**: Examination of the end portion of the colon.

* Dilation: esophageal stricture, treatment may be performed by various means, including manual, wire guided or balloon Dilation of dilators of graded size.
** Procedural Sedation provides a state of relaxation sufficient to tolerate procedure. Intravenous medications will be used for sedation. This will be administered under the supervision of your physician or the anesthesiologist.

Others: _____

Principal risks and complications of gastrointestinal endoscopy: Gastrointestinal endoscopy is generally a low-risk procedure. However, all of the below complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indication for gastrointestinal endoscopy.

» Perforation: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal con tents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required. A permanent colostomy may be placed by surgeons depending on the site of perforation.
» Bleeding: Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, may require transfusions or possibly a surgery.
» Medication phlebitis: Medications used for sedation may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist up to several months.
» Risks of medication used for Conscious (Moderate) sedation or sedation by the anesthesiologist include but are not limited to cardiopulmo nary complications that range from mild vital sign changes to heart attack, impaired breathing, respiratory arrest and low blood pressure. Skin irritation at the site of I.V., skin rash, irregular heart rhythm, and anaphylactic reaction may occur.
» Respiratory depression: The sedation used for this procedure will occasionally suppress breathing. Assisted breathing may be necessary until the sedation wears off.
» Other potential risks: Including but not limited to drug reactions and complications from other diseases you may already have. Instrument failure and death are extremely rare, but remain remote possibilities. You must inform your physician if any allergies and medical problems.

The practical alternatives to this procedure: Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100% accurate in diagnosis. In a small percentage of cases, a failure diagnosis or a 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.

Unforeseen procedures: I understand that during the course of the procedure described above, it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

Specimens: I consent to diagnostic studies, tests, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. I consent that any tissues or specimens removed from my body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider. I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

Moderate (Conscious) or Monitored Anesthesia Care (MAC) Sedation Administration: My physician has reviewed the risks of sedation with me. The anesthesiologist may administer monitored anesthesia care (MAC). I accept these risks and consent to the

administration of moderate or monitored anesthesia care. No guarantee has been made as to the results thereof. I have arranged to have a responsible person drive me home. I understand that impairment of full mental alertness may persist for several hours following the administration of sedation and I will avoid making decisions or taking part in activities, which depend on full concentration or judgment during this period.

Practice of medicine: I understand the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure.

Patient Valuables / Personal Property: I have been instructed to leave valuables at home or place them in the care of family members. I understand and agree that the center shall not be liable for loss or damage to any personal property unless deposited with the center for safe keeping. The liability of the center for loss of any personal property so deposited is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the center by the patient

Consent to Use and Disclosure of Protected Health Information: My protected health information (PHI) may be used by the Center or disclosed to others for the purposes of treatment, obtaining payment, or reporting the day-to-day health care operations of the practice. I have received a copy of the Centers Notice of Privacy Practices and agree that that the Center may use my information as provided in said policy. I understand
that I may request a restriction on the use or disclosure of my protected health information. The Center may or may not agree to restrict the use or disclosure of my PHI. If the Center agrees to my request, the restriction will be binding on the center. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The Center reserves the right to modify the privacy practices outlined in the notice.

Photographic Consent: I consent to the photographing and / or videos of the operation, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Payment Obligations: I authorize direct payment from my insurance company for certain costs for medical equipment, disposables (sterile supplies, etc) or services that may arise during the performance of the above operation(s) which may be billed collectively as a “facility fee” to my insurance company by the surgery center. The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of outpatient services, including emergency services if rendered, provided to the patient, he/she hereby individually obligates himself/herself to
pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys’ fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Shadelands Advanced Endoscopy Institute, Inc. specifics: The benefits and risks of having the procedure at this outpatient facility versus a hospital or other Ambulatory Surgery Centers have been explained to me in general terms and I agree. I am aware that my physician may have a financial interest in Shadelands Advanced Endoscopy Institute, Inc. I understand that other physicians (if any) furnishing services to the patient, including the anesthesiologist, pathologist, radiologist, and the like, are independent contractors and are not employees or agents of the Center. I understand that these physicians will bill me separately for their services. I am aware that if I have an advance directive it is temporarily suspended while I am a patient at Shadelands Advanced Endoscopy Institute, Inc., as Shadelands Advanced Endoscopy Institute, Inc. considers all patients undergoing procedures considered eligible for life-sustaining emergency treatments and transfer to a higher level of care. I understand that if my condition requires care that is not within the capabilities of Shadelands Advanced Endoscopy Institute, Inc., I will be transferred to an acute care facility.

Certification: The undersigned certifies that he / she has read and understood this Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of my Protected Health Information. I understand that this is a continuing consent and is valid for a period of thirty (30) days. By signing this form, I acknowledge that the risks, benefits and alternatives to the above procedure have been explained to me, that I have read or had this form read and/or explained to me in general terms, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All related blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information, including but not limited to the materials listed below, related to the procedure described herein.

I hereby request and consent to __DR. R. SHARMA ___DR. C. MULLEN. ___DR. A. VAZIRI___ S. WADHWA___ M. HOSSEINI __S.NARAYAN __H. CHENG __L. HIGA _N.SALEHOMOUM as my physician, or. Dr. _____ and any other physician(s), and such associates, assistants or other medical personnel involved in performing such procedure(s) described or referred herein.

Do not sign this form until all questions have been answered to your satisfaction.

Patient signature: _____ Date & Time: __/__/_____, ____:____AM/PM

Guardian name/relationship/ and signature: _____ Date & Time: __/__/_____, ____:____AM/PM

_____

(Patient unable to sign because: _____)

Witness to signature: _____ Date & Time: __/__/_____, ____:____AM/PM

BASS
MEDICAL GROUP

FINANCIAL POLICY

- I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.
- It is my responsibility to verify with my insurance if BASS Medical Group is a contracted provider. BASS and/or its representatives will make every effort to assist you, but BASS will not be held accountable for understanding every insurance plan.
- I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.
- I authorize the release of any medical or other information necessary to process claims for payment.
- I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.
- I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group. immediately upon receipt.
- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts.
- I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
- I, the patient, or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.
- Lab services: I understand some or all laboratory tests may be sent to an outsourced lab for processing when necessary.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the laboratory department of BASS Medical Group.

_____	_____	_____
Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).

- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  *Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name. alternative address. phone number. & email address of Spouse. as applicable:**

  _____

  ☐ **OK to Family Members: Please list name(s). alternative address. phone numbers. & email addresses of Family Member(s). as applicable:**

  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s). alternative address. phone numbers. and email addresses of authorized person(s) or entities:**

  _____

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address:

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing.
You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/ they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

PONTINE

Anesthesia Consultants

Anesthesia Services – Assignment of Benefits

Assignment of Benefits: I hereby assign to and authorize payment directly to Pontine, Inc. (the "Provider") of all benefits due the Provider under Medicare, Medicaid, or any insurance policy providing benefits for Provider charges, for services rendered by the Provider.

Release of Information: I irrevocably agree that the Provider may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the Provider, and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the Provider or to me, or any person or entity responsible for all or part of the Provider's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the Provider or by my physician for continued care; (d) any physician or Certified Registered Nurse Anesthetist (CRNA) treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents or employees.

Financial Agreement: In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the Provider and my third party payor, I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE PROVIDER AT THE USUAL AND CUSTOMARY CHARGE OF THE PROVIDER. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. I understand that I am financially responsible for charges not paid within said 60 days of service and for charges not covered by this assignment. I understand that the Provider files for reimbursement from my insurer or other payor as a courtesy and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the Provider. I also authorize the Provider, without further actions from me, to file appeals on my behalf to my insurer for under or unpaid claims of service. I also understand that the Provider may or may not have a contracted relationship with my insurer for a reduced rate from the usual and customary charge of the Provider and I will fully accept the Provider to provide clinical services that may or may not be considered contracted or "in-network" with my insurer.

Even though I have assigned my benefits to the Provider, in the event my Insurance Company sends payment for services rendered at the surgical facility directly to me, I agree to immediately remit the payment to the Provider. I agree to forward to the Provider any Explanation of Benefit(s) form that my insurer may send to me as well as disclose any and all payments received from the insurer for services rendered by the Provider. Failure to remit entire amount paid by my insurance company to me will result in immediate collection action of the full billed amount.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due. Provider employees are not able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier. A photostatic copy of this agreement shall be considered effective and valid as the original.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

_____ Date _____

Patient Signature

_____ Date _____

Guarantor Signature

_____ Date _____

Anesthesiologist Signature

PATIENT HEALTH HISTORY

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE

NAME: _____ AGE: _____ ☐ M ☐ F Ht: ☐ Wt: ☐

ALLERGIES: ☐ NONE ☐ Latex ☐ Medications/Other: _____

Describe the Allergic Reaction:

When did you last eat solid food? hour _____ am/pm _____ date

When did you last drink liquid? hour _____ am/pm _____ date

Can you climb 2 flights of stairs without chest pain or shortness of breath? Yes/No

HAVE YOU HAD? Circle Yes or No and circle the problem you've had. Explain if necessary:

Neurologic disease (e.g., seizures, fainting, stroke)	YES	NO	
Psychiatric illness (e.g., anxiety, panic, depression)	YES	NO	
Abnormal repsonse to sedating medications	YES	NO	Sensitive or Resistant
Heart disease (e.g., chest pain, heart attack, failure, coronary artery disease, valve disease, murmur)	YES	NO	
Arrhythmia (e.g., A-Fib), Pacemaker, Defibrillator	YES	NO	
High blood pressure	YES	NO	
Loud snoring, obstructive sleep apnea, CPAP	YES	NO	
Lung disease (emphysema/COPD, asthma, wheezing)	YES	NO	
Recent cough, cold, fever, chills	YES	NO	
Liver disease (e.g., hepatitis, cirrhosis)	YES	NO	
Kidney disease, dialysis	YES	NO	
Thyroid disease (e.g., low thyroid or high thyroid)	YES	NO	
Diabetes: Type I or Type II	YES	NO	(Nurse's Use) Glucose:
Anemia, abnormal bleeding, abnormal blood clot	YES	NO	
GI disease (e.g., esophagus, stomach, intestine, GERD)	YES	NO	
Arthritis, chronic pain	YES	NO	
Cancer, immune disease	YES	NO	
Recent pregnancy, breastfeeding	YES	NO	
Recreational drug use within the last year	YES	NO	
Smoking	YES	NO	Packs per day:
Alcohol Use	YES	NO	Drinks per day:
OTHER MEDICAL PROBLEMS:	YES	NO	
SURGERIES IN THE PAST 2 YEARS:	YES	NO	

PLEASE CIRCLE YES OR NO:

- Have you had endoscopy or colonscopy before? YES/NO
- If so, any problems with your sedation? YES/NO
- Have you ever had any problems with anesthesia? YES/NO
- Have relatives had problems with anesthesia? YES/NO

DO YOU NOW HAVE:

- Dentures/Bridges/Loose Teeth YES/NO
- Eyesglasses/Contact Lenses YES/NO
- Hearing Aid(s) YES/NO
- Metal in body (e.g., replaced joint) YES/NO

"I understand that I should not drive or operate potentially dangerous machinery until the day after my sedation."
"I understand that if a condition arises my physician may feel admission is required to a hospital, he/she may admit me as an in-patient."
"I have left all valuables at home or in the care of others and hereby release the surgery center from responsibility for the same"
"I have arranged for a responsible adult to take me home today."

Signature (Patient) _____

Signature (Pre-Op Nurse) _____

Patient Sticker

PLEASE SEE SECOND PAGE - MEDICATION LIST

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE, INC.

MEDICATION RECONCILIATION FORM

PATIENT NAME: _____

Information Source: ☐ Patient ☐ Family ☐ Medication bottle ☐ Wallet card ☐ Other: _____

ALLERGIES AND REACTION:

Patients to complete the first 4 columns (Please use black ink):

List all prescription, over-the-counter, vitamins, and herbal/natural medications taken routinely	DOSE	Frequency	Route (oral) (Others)	When was The Last Dose Taken?	Continue upon discharge	Discontinue	Check with Primary Doctor	COMMENTS

Pre-Op Nurse obtaining list: _____ **Date:** _____ **Time:** _____

PHYSICIAN ORDERS:

Discharge Medication	Dosage	Frequency	Duration	Comments

REMARKS: _____

☐ Please resume medications which have been prescribed to you when you return home unless otherwise indicated.

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

NURSE DISCHARGING PATIENT: _____ **DATE:** _____ **TIME:** _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____ **TIME:** _____

☐ COPY ATTACHED TO DISCHARGE INSTRUCTIONS.

498 N. Wiget Lane, Walnut Creek, CA 94598
Tel: (925) 933- 3600 Fax: (925) 933- 7900

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE

Permission for Disclosure

Without your written permission, we cannot speak to anyone about your visit or medical records. Please list the names of people that you allow us to speak with (such as spouse, parents, or family members).

_____

_____

_____

_____

_____

_____

_____

_____

X _____

(Patient's Signature) (Date)

Patient Transport Information

Driver's name _____ Relationship _____

Telephone numbers:

Home _____

Cell _____

Other _____

Call ahead time _____ minutes

In waiting room (circle one) YES NO

SHADELANDS ADVANCED ENDOSCOPY INSTITUTE, INC.

498 N. Wiget Lane | Walnut Creek, CA 94598 | Tel.: (925) 933 3600 | FAX: (925) 933 7900

ACKNOWLEDGEMENT FORM

Dear Patient:

We are required to inform you of the following information prior to your procedure. Please review the following information and sign below:

I, _____ have received and reviewed the Shadelands Advanced Endoscopy Institute, Inc. policies and procedures concerning the following.

I have been allowed to ask questions and am satisfied with the information provided as follows:

- **Patient right and responsibilities. This form also includes Information on how to file a complaint or grievance**
- **Information regarding informed consent for my procedure. This form also includes:**
  - **Consent form**
- **Notice of Privacy Practices (HIPAA)**

Signature _____ **Date of signing** _____

Remarks: _____

_____

_____

_____

_____

_____

SHADELANDS ADVANCED ENDOSCOPY
INSTITUTE, INC 498 N. Wiget Lane
Walnut Creek, CA 94598
Phone: 925-933-3600 | Fax: 925-933-7900

PATIENT RESPONSIBILITIES

PURPOSE:

The purpose of this policy is to outline patient responsibilities in regards to their appointment, cooperation, and information provided for insurance claims as determined by rules and regulations.

- It is the patient's responsibility to know their patient's rights and responsibilities.
- It is the patient's responsibility to fully participate in decisions involving your health care and to accept the consequences of these decisions if complications occur.
- It is the patient's responsibility to report whether you clearly understand the planned course of treatment and what is expected of you.
- It is the patient's responsibility to keep your appointment, and when unable to do so, notify the facility and your physician, in an appropriate timely matter.
- It is the patient's responsibility to provide caregivers with the most accurate and complete information regarding present complaints, past illnesses, hospitalization, medications, unexpected changes in the patient's condition, or any other health matters.
- It is the patient's responsibility to follow up on your physician's instructions, comply with the treatment plan, take medication when prescribed and ask questions concerning your health care that you feel are necessary.
- It is the patient's responsibility to inform the endoscopy Center of all medications and dosages currently taken or prescribed to them, including over-the-counter products as well as dietary supplements, and any allergies or Sensitivities.
- It is the patient's responsibility to observe the rules of the facility during your stay and treatment. if instructions are not followed, you forfeit the right to patient care in the facility.
- It is the patient's responsibility to be considerate of others and the facility and to identify any patient safety concerns.
- It is the patient's responsibility to provide the facility with current insurance information and promptly fulfilling your financial obligation to the facility.
- It is the patient's responsibility to provide a responsible adult to transport you from the facility and remain with you for 24 hours if required by the facility or physician.

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PATIENT'S BILL OF RIGHTS

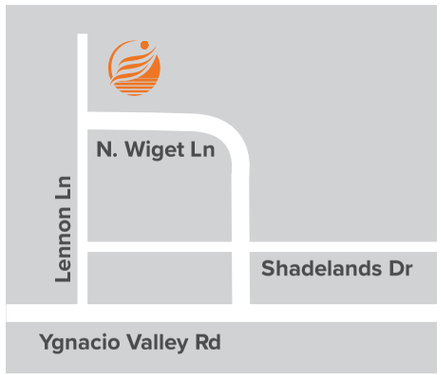
PURPOSE:

Shadelands, Advanced Endoscopy Institute, Inc. observes and respects patient's rights and responsibilities without regard to age, race, gender, national origin, culture, physical or mental disability, personal values, or belief systems. It is recognized that a personal relationship between the physician and patient is essential for the provision of proper medical care. Your patient's rights include the following.

- A Patient has the right to respectful care given by competent personnel, in a safe setting
- A Patient has the right to be free from all forms of abuse, neglect, and harassment.
- Patient has the right, upon request, to be given the name of his attending practitioners, the names of all other practitioners directly participating in his care, and the names and functions of other health care persons having direct contact with the patient
- A Patient has the right to consideration of privacy concerning his medical care program. Case discussion, consultation, examination, treatment, and medical records are considered confidential and shall be handled discreetly.
- A Patient has the right to confidential disclosures and records of his medical care except as otherwise provided by law or third-party contractual arrangement
- A Patient has the right to participate in decisions involving his health care except when such participation is contraindicated for medical reasons.
- A Patient has the right to know what Shadelands Advanced Endoscopy Institute, Inc. rules and regulations apply to his conduct as a patient.
- The Patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The Patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- The Patient has the right to full information, in layman's terms, concerning diagnosis, evaluation, treatment, and prognosis. including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the person designated by the patient or to a legally authorized person.
- Except for emergencies, the practitioner shall obtain the necessary informed consent before the start of a procedure.

Shadelands Advanced Endoscopy Institute, Inc.
Division of BASS Medical Group

498 N. Wiget Lane
Walnut Creek, CA 94598
Ph: (925) 933-3600
Fx: (925) 933-7900



We are contracted with most insurance plans.
For questions, call:
(925) 391-1446

Monday–Thursday: 8:00 a.m.–5:00 p.m.
Friday: 8:00 a.m.–3:00 p.m.

BASS MEDICAL GROUP

www.bassmedicalgroup.com

Patient Information

Shadelands Advanced Endoscopy Institute, Inc

A DIVISION OF BASS MEDICAL GROUP

Preparation for your Procedure

- A nurse will call you 1-2 days prior to your procedure to review your medical history. Please have a list of your medication including the dosages available. If it is more convenient, you may call our nurse between 8:30am and 4pm at (925) 933-3600.
- Please call your gastroenterologist if you do not know which medication including blood thinners Coumadin (warfarin), Pradaxa, aspirin, Plavix, Aggrenox or diabetes medications should be on hold. If the physician feels it is safe, he/she may hold your blood thinners such as coumadin and plavix for 3-7 days before your procedure.
- Transportation arrangements need to be made before the day of your procedure. You must arrange for someone to drive you home. You are not allowed to drive after receiving sedation. If you need to take a taxi, you still need to have a responsible adult with you. The taxi driver cannot take responsibility for you due to liability issues.
- Bring your photo ID and insurance card(s).
- Wear loose comfortable clothing and flat comfortable shoes.
- Leave jewelry, money and valuables at home. The center cannot be responsible for them during your stay.
- Please call our center at least 3 business days if you are unable to keep your appointment. This will help to accommodate other patients in need.
- Please notify us in advance if English is not your primary language. We will provide a free interpreter for you.

Your Procedure Date

Day of your Procedure

- When you arrive at the center you will be greeted by our receptionist who will assist you with your registration.
- You will then be escorted to the preoperative area where a nurse will complete the admitting process. Here you will change into a gown and have your IV started. You will also meet your procedure room nurse who will escort you to the procedure room.
- After the procedure you will be taken to the recovery area where you will stay until you are awake enough to go home. At that time you will dress and receive your discharge instructions. You will then be escorted and assisted by the staff into your family or friend's car.
- Relax for the rest of the day. Have someone check on you every couple of hours. If you experience any problems after you arrive home, please notify your physicians office.

Meet our Team

Rishi Sharma, MD

GASTROENTEROLOGY

Dr. Sharma has been with BASS for 4 years and specializes in general gastroenterology and hepatology conditions. For Dr. Sharma, medicine has never been a career, it has been a passion with a dedicated interest in working together with patients to create excellent health care outcomes.

Cynthia Mullen, MD

GASTROENTEROLOGY

Dr. Mullen has extensive experience in the management of gastrointestinal and liver disorders.. Her passion and enthusiasm for clinical and academic gastroenterology further strengthen our commitment to high-quality patient care here at BASS.