Red Bank Gastroenterology ASSOCIATES
Endoscopy Center of Red Bank
365 Broad Street Red Bank, New Jersey 07701
T: 732-842-4294 T: 732-842-9129 F: 732-548-7408 www.rbgastro.com

JOSEPH F. BINNS, MD
JOSEPH A. MARZANO, MD
ROBERT J. GIALANELLA, MD
GREGORY J. HEYT, MD
Y. ALEXIS CHOI, MD
HOWARD HAMPEL, MD, PhD
DOUGLAS M. WEINE, MD
SUBHA SUNDARARAJAN, MD
BOARD CERTIFIED IN
GASTROENTEROLOGY & HEPATOLOGY

Dear Patient: _____ Date: _____

Welcome and thank you for choosing Red Bank Gastroenterology. The enclosed information is intended to ensure that your experience at our facility is as efficient and comfortable as possible. Please read through this whole packet of instructions immediately as they are time sensitive, complete all included forms and return them to our office before the date of your appointment. These can be Emailed, Faxed or dropped off. Please note that if you mail back your forms you may have to fill them out again if they are not received prior to your appointment.

Because your appointment is uniquely devoted to you, we do ask that you make every effort to keep your designated time. We are happy to reschedule your procedure if need be, but please give us at least a 48 hour prior notice if possible per our cancellation policy. Thank you.

PROCEDURE: UPPER GI ENDOSCOPY (EGD)

PHYSICIAN: _____

LOCATION: The Endoscopy Center of Red Bank, 365 Broad Street, 2nd Floor

DATE: _____

ARRIVAL TIME: [ ] *Morning* 7:00-11:30AM [ ] *Afternoon* 12:30-4:00PM

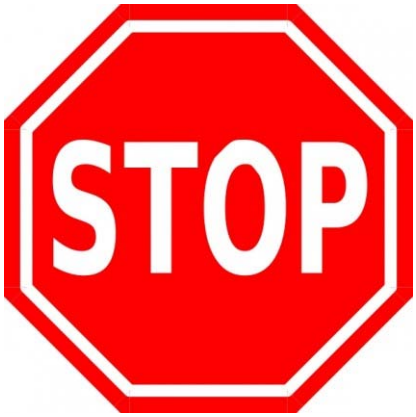
***Confirmed Arrival Time:** _____
Please fill in the time when you receive your confirmation call.

**Appointment time subject to change: You will receive a confirmation call on the business day prior to your procedure at your provided primary phone # with your actual confirmed time of arrival. Since your arrival time may change, please keep this in mind when arranging your transportation. If you miss the call, please call the Endoscopy Center (see number below) at 3:00PM the same day.*

HELPFUL PHONE NUMBERS/CONTACTS:
Endoscopy Center of Red Bank: 732-842-9129
After Hours: 732-842-4294 *main number, answering service will page physician on-call*
Fax: 732-548-7408
ADH Billing: 732-222-3805

Cancel/Reschedule: _____ at direct phone # _____
Please bring this entire packet with you on the day of your procedure.
Thank you very much.

Fasting Guidelines for Patients who are Receiving Sedation



FOUR HOURS before your procedure,
No water/No chewing gum/No liquids at all

NOTHING BY MOUTH

Even your CLEAR LIQUIDS must be stopped.

*PLEASE NOTE EXCEPTION:
The morning of your procedure you MUST take your regularly scheduled blood pressure, cardiac, breathing, and anti-seizure medications with a small sip of water.

Please bring your inhaler if you use one.

You may brush your teeth or use mouthwash before you come, but please do not swallow any liquids.

Please do not wear heavy perfumes or creams. It is ok to use deodorant.

Please read through this entire instruction packet.

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UPPER GI ENDOSCOPY (EGD) PROCEDURE INSTRUCTIONS

BEFORE SCHEDULING YOUR PROCEDURE, WE WILL NEED THE FOLLOWING:
1. COPIES OF YOUR INSURANCE CARDS (BOTH SIDES):
If your insurance card is in your spouse's name, please include his/her name and birth date.

2. COPIES OF REFERRALS IF NEEDED:
Please call or check the back of your insurance card to see if your insurance requires a referral or "prior authorization" and notify our office if so. If you need a referral, contact your referring doctor's office. It is your responsibility to get a referral form from your primary doctor should you need one, and drop off/fax/email us a copy no later than 4 business days prior to your procedure, or it may be canceled. A referral is not the same as a prescription.

3. COMPLETED REGISTRATION, PATIENT'S RIGHTS and BILLING FORMS:
If you have been seen in the office recently this calendar year, we may already have copies, otherwise they will be provided in this packet as we need all your new updated information. If we do not already have them, they can be dropped off/faxed/emailed. Please note that if you mail back your forms you may have to fill them out again if they are not received prior to your appointment.

THE WEEK BEFORE YOUR PROCEDURE
Please read through your entire packet. Make arrangements for transportation. It is not permissible for you to walk, take a taxi, or drive yourself home after your procedure. You must have someone with you to drive you home or your procedure will be cancelled. You will be at our Endoscopy Center for about two hours. We can call your ride for you, or they can stay in the waiting area during your procedure.

THE DAY OF YOUR PROCEDURE
NO SOLID FOODS at all for EIGHT HOURS prior to your procedure. If your procedure is scheduled in the afternoon and you wake up early you may have tea & toast only up until 8 hours before your arrival time. Then you may have CLEAR LIQUIDS which are anything you can see through. *No coffee or milk.*

NOTHING TO EAT/DRINK at all, NOT EVEN WATER FOUR (4) HOURS before your procedure except for a small sip of water with your needed medication(s). You may brush your teeth or use mouthwash but please do not swallow any liquids.

MEDICATIONS: You should take your regular medications before your procedure. Please bring a list of all your current medications and their dosages including over the counter medications, vitamins and supplements. If you have any questions, please do not hesitate to call. You must take your cardiac and blood pressure medications (including the morning of your procedure) with small sips of water only. If you use an inhaler, bring it with you please. You can continue taking your Aspirin.

IF CHECKED OFF ONLY: You must consult with your cardiologist first and coordinate with our office.

_____ STOP PLAVIX _____ DAYS BEFORE YOUR PROCEDURE

_____ STOP COUMADIN _____ DAYS BEFORE YOUR PROCEDURE

_____ STOP ( ) _____ DAYS BEFORE YOUR PROCEDURE

Type 2 Diabetics: Do NOT take your oral diabetes medication while on your clear liquid diet/fasting.

Type 1 Diabetics: Check with your Endocrinologist regarding your insulin.

FEMALE PATIENTS UNDER AGE 55: Please refrain from voiding before you arrive for your procedure as you will be required to provide a small urine sample for a pregnancy test before you receive sedation.

UPPER GI ENDOSCOPY (EGD)

Upper GI endoscopy—or esophagogastroduodenoscopy (EGD)—is a visual examination of the lining of your esophagus, stomach, and the first part of your intestine. This is performed by passing a flexible scope through your mouth, under sedation. Your doctor will be able to look for any abnormalities that may be present. If necessary, small tissue samples (biopsies) can be taken during the examination (painlessly) for detailed laboratory analysis.

Some treatments can also be done through the endoscope. These include stretching (dilating) narrowed areas of the esophagus, stomach, or duodenum, removing polyps and swallowed objects, and treatment of bleeding vessels and ulcers by internal injection or application of heat (using electrical diathermy or heat probes).

Preparation

Your stomach must empty. See detailed instruction sheet.

What Will Happen

The doctor and/or nurse will explain the procedure and answer your questions. Please tell them if you have had any allergies or bad reactions to medications or latex. You will be asked to sign a consent form, giving your permission for the examination. You will need to put on a hospital gown and remove your eyeglasses and dentures.

Your blood pressure and pulse will be monitored continuously throughout the procedure and nasal oxygen will be applied. You will be given medication by injection through an I.V. by an anesthesiologist to make you sleepy and relaxed. While in a comfortable position on your left side, the doctor will pass the endoscope through your mouth and down your throat. A guard will be placed to protect your teeth. The instrument will not interfere with your breathing or cause any pain. The examination takes 10–30 minutes.

Afterward

You will remain in the recovery area for up to 1 hour, until the main effects of any medication wear off. Your throat may feel slightly sore. After this, you may return to your regular diet, unless otherwise instructed. You may feel slightly bloated, due to air that has been injected through the endoscope; this will quickly pass.

A companion must be available to drive you home. For the remainder of the day you should not drive a car, operate machinery, or make important decisions, as the sedation impairs your reflexes and judgment.

Risks?

Endoscopy can result in complications such as reactions to medication, perforation of the intestine, and bleeding. These complications are very rare (less than 1 in 5000 examinations), but may require urgent treatment and even an operation. The possibility of complication is greater when the endoscope is used to apply treatment. Be sure to inform us if you have any pain, black tarry stools, or troublesome vomiting in the hours or days after endoscopy.
No guarantee has been given as to the results that may be obtained. The possibility of missing significant lesions or cancer does exist, but occurs rarely.

The medication used for sedation should not be used if pregnant. Please notify the doctor if pregnancy is a possibility.

CLEAR (TRANSPARENT) LIQUID DIET

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed.

No Red or Purple liquids (they may look like blood) and **you may not have** coffee, milk or anything opaque. Alcoholic beverages are **not** permissible.

YOU MAY HAVE:

Beverages

1. Apple juice
2. Clear (white) cranberry/grape juice
3. Crystal Light®
4. Lemonade
5. Soda, Sprite, ginger ale, seltzer
6. Sports drinks
7. Tea, hot and iced
8. Transparent coconut water
9. Transparent protein drinks
10. Water

Clear Broth

1. Chicken, beef, vegetable
2. Bouillon
3. Broth
4. Consommé

Desserts

1. Lemon popsicles
2. Lemon ices
3. Favored gelatin "Jello®"

(No red or purple flavors, No fruit chunks)

Miscellaneous

1. Sugar, honey, syrup
2. Clear, hard candy
3. Salt

You may brush your teeth or use mouthwash.

Please do not swallow any liquids

YOU MAY NOT HAVE:

Red, purple colors, coffee, milk or anything opaque.

Alcoholic beverages of any kind are not permitted.

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RIGHTS OF PATIENT

DISCLOSURE OF OWNERSHIP*: Your Physician does have a financial interest in the facility. The medical staff, governing body, and personnel of the Endoscopy Center of Red Bank recognize the basic human rights of patients. Efforts are directed to providing care commensurate with those basic human rights. Patients have the right to:

- Be informed of his or her rights as a patient in advance of receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for care.
- Considerate, respectful, and dignified care, provided in a safe environment, free from all forms of abuse, neglect, harassment, and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her. The patient has a right to change providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Be advised as to the absence of malpractice coverage if applicable.
- Receive complete information from his/her physician about his/her diagnosis, illness, course of treatment, risks, benefits, alternative treatments, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand. Your physician should discuss these with you prior to the procedure and give you the opportunity to ask any questions you may have.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment of non-treatment, and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed by the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding, and as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should the patient wish to communicate a concern regarding the quality of care received. The patient can file a grievance with the facility's Director of Nursing Services at 732-842-9129, ext. 137, by e-mail at gperentesis@rbgastro.com, or by mail, at 365 Broad Street, Suite 2E, Red Bank, NJ 07701; or the patient can file a grievance with the New Jersey State Department of Health and Senior Services/Consumer and Environmental Health Services at PO Box 369, Trenton, NJ 08625-0369. A grievance may also be filed with AAAHC @ 5250 Old Orchard Road, Suite 200, Skokie, IL 60077, Phone 847-853-6060. If the patient files a grievance with the surgery center, he/she will be provided with a written notification of the grievance determination containing the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date. Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman. www.cms.hhs.gov/center/ombudsman.asp or NJDOHSS Complaint Hotline: 1 800-792-9770
- Be advised if the facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment, or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a fully informed consent process as it relates to the research, investigation, and/or clinical trial. All information provided to the subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- All facility personnel, medical staff members, and contracted agency personnel performing patient care activities shall observe these patients' rights.
- To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43E-6.

*DISCLOSURE: The Endoscopy Center of Red Bank is a corporation whose investors are Dr. Joseph Binns, Dr. Robert Gialanella, Dr. Gregory Heyt, Dr. Y. Alexis Choi, Dr. Howard Hampel, Dr. Douglas M. Weine, and Dr. Subha Sundararajan. The physician investors have established the ambulatory surgical center, designed primarily for performing endoscopic procedures, and refer patients to the Endoscopy Center of Red Bank for procedures. The Red Bank Gastroenterology Laboratory was developed to facilitate timely, accurate pathologic interpretation of endoscopic biopsies and is staffed by a Pathologist with dedicated training in Gastroenterologic Pathology.

Patients Signature indicating awareness of above_____ Date_____

ADVANCED DIRECTIVE–LIVING WILL

On January 11, 1992, a New Jersey law took effect which mandates that all health care facilities ask patients whether they have an Advanced Directive or Living Will. At The Endoscopy Center of Red Bank we have made this a part of our admitting process.

An Advanced Directive or Living Will is a document which allows you to give written instructions to those caring for you indicating the type of health care you would wish to receive or reject in the event you become unable to express these decisions yourself. If you have an Advanced Directive or Living Will, please bring a copy of it with you to the center on the day of your procedure. While you are a patient at the Endoscopy Center of Red Bank, your Advanced Directive WILL NOT be honored. Should you be transferred to a hospital, a copy of your Advanced Directive will be sent with you.

There are three different types of Advanced Directives:

1. **A PROXY DIRECTIVE** This is a document in which a competent adult names a trusted relative or friend to make health care decisions ☐on their behalf when they are unable to make these decisions.

2. **AN INSTRUCTION DIRECTIVE** In this document, the person writing it provides written instructions concerning the type of medical treatment ☐they want or do not want performed for them and under what circumstances.

3. **A COMBINED DIRECTIVE** In the document, a competent adult stated their general wishes regarding the kind of health care they wish to receive but appoints a trusted relative or friend to carry them out. ☐

A brochure containing living will information is available from the Division of Aging. If you wish to receive a brochure, please make your request to:

The Division of Aging
101 South Broad Street
CN807
Trenton, NJ 08625

For more information contact:
State of New Jersey Department of Health and Senior Services
P.O. Box 360, Trenton, NJ 08625-0360
Phone: (609) 292-7837
www.state.nj.us/health/advanceddirective/ ☐

Do you have an ADVANCED DIRECTIVE OR LIVING WILL? _____YES_____NO

If yes, please send or bring it to the center prior to your scheduled procedure.

Patients Signature indicating awareness of above_____ Date_____

RESPONSIBILITIES OF PATIENTS

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities are presented to the patient in the spirit of mutual trust and respect:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary and herbal supplements) and dosages, allergies and sensitivities, and other matters relating to the patient's health.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- It is the patient's responsibility to notify the facility if he/she has not followed the pre-operative instructions given by their physician and/or facility personnel.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- In the case of pediatric patients, a parent or legal guardian must remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible. Ultimate financial responsibility is the patient's, regardless of the insurance coverage he/she may have.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's Advance Directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.
- Patient's signature represents he/she has received written and verbal information regarding physicians' financial interest in the Facility, Advance Directives, grievance process and on the informed consent process prior to the day of their procedure.

APPOINTMENT CANCELLATION / NO SHOW POLICY

Red Bank Gastroenterology and the Endoscopy Center of Red Bank requires notice for a cancelled appointment. If you are unable to keep your procedure appointment two business day notice is required. There will be a $300 charge for a missed procedure. If you are unable to keep your Office Appointment a 24 hour notice is required. There will be a $75 charge for missed office appointments. It is not our intent to inconvenience any of our patients, but in order to run our office as efficiently as possible we need to utilize canceled appointments for other patients.

BY SIGNING BELOW:

I acknowledge that the Endoscopy Center of Red Bank has provided me with information regarding:

A. Patient Rights and Responsibilities including cancellation policy☐

B. Physician ownership☐

C. Information about Advance Directives *Including information about how to formulate an advance directive, (if needed)*

D. APPOINTMENT CANCELLATION / NO SHOW POLICY
I am aware that if I need to cancel or reschedule my procedure, 2 business days' notice are required or I am subject to a $300 charge and for office appointments a 24 Hour notice is required or I am subject to $75 charge.

Patients Signature indicating awareness of above_____ Date_____

Phone #_____ permission is given to leave a message for arrival time and billing messages only.

Authorization will remain in effect until our office receives written notification. _____

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REGISTRATION INFORMATION *Please completely fill out, date & sign*

DATE_____

PATIENT NAME Last_____ First_____ MI___ BIRTHDATE_____ AGE_____

___Male ___Female EMAIL_____ SS#_____ MARITAL STATUS_____

YOU MUST PROVIDE at least one phone number strictly for Appointment Confirmation Calls. No medical information will be discussed. Authorization will remain in effect until our office receives written notification. Please indicate preferences below.

Primary Phone_____ Home / Cell / other specify: _____Yes __/ No __ Ok to leave message on phone/with person.

Second Phone_____ Home / Cell / other specify: _____Yes __/ No __ Ok to leave message on phone/with person.

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

How did you hear about our practice? _____

PRIMARY CARE PHYSICIAN/ ADDRESS _____PHONE_____

REFERRING PHYSICIAN / ADDRESS _____ PHONE_____

PATIENT'S EMPLOYER_____ WORK PHONE_____

WORK ADDRESS_____ CITY_____ STATE_____ ZIP_____

PRIMARY INSURANCE_____ POLICY/ID#_____ GROUP#_____ EFFECTIVE_____

If Medicare: Part B Start Date_____ (For Primary or Secondary Insurance)

CLAIMS ADDRESS_____ CITY_____ STATE_____ ZIP_____

SUBSCRIBER'S NAME *policy holder*_____ BIRTHDATE_____ RELATIONSHIP_____

EMPLOYER_____ ADDRESS_____ CITY_____ STATE_____ ZIP_____

SECONDARY INSURANCE _____ POLICY/ID#_____ GROUP#_____ EFFECTIVE_____

CLAIMS ADDRESS_____ CITY_____ STATE_____ ZIP_____

SUBSCRIBER'S NAME *policy holder*_____ BIRTHDATE_____ RELATIONSHIP_____

EMPLOYER_____ ADDRESS_____ CITY_____ STATE_____ ZIP_____

Pharmacy Name / town_____ Pharmacy Phone_____

Prescription Card_____ Rx Card Number_____

MANDATORY FIELDS Permission given to call with test results, messages from doctor, biopsies, billing etc. to:

This permission will remain in effect until we are notified in writing otherwise. You must provide at least one contact.

Myself_____ Phone#_____ Answering machine (ok to leave message?): Yes__ / No__

Other person/s_____ Relationship_____ Phone#_____ Answering machine: Yes___ / No__

Other person/s_____ Relationship_____ Phone#_____ Answering machine: Yes___ / No__

FOR MEDICARE ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Red Bank Gastroenterology Associates for any services furnished me by Red Bank Gastroenterology Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE:_____ DATE:_____

FOR ALL OTHER INSURANCE ASSIGNMENT OF BENEFITS: I hereby authorize and instruct any and all insurance companies involved with my healthcare coverage to make payment directly to Red Bank Gastroenterology Associates. This is for the Professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay in current fashion any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any of information pertinent to my case to my Insurance Company or adjuster involved in the case, unless I have made alternative arrangements with respect to this data:

PATIENT'S SIGNATURE:_____ DATE:_____