Patient:	Date:
Arrival Time:	SUITE:

General Instructions

- You will be sedated for this procedure. You will not be able to drive yourself home. You MUST bring someone with you to drive home. If you plan to take public transportation home, you MUST bring a responsible adult with you. If you do not have a responsible adult to take you home, the procedure will be cancelled.
- Expect to spend 2-4 hours at the facility (depending on previous cases that are being done that day). Please be patient, as every case is different.
- Female Patients: If you could be pregnant or seeing a fertility doctor, please notify our office.
- If your insurance changes before your procedure, notify our office.
- Appointment cancellations require a 48-hour notice or a charge will be incurred.
- Avoid endoscopic procedures for the first 3 months following placement of a cardiac stent, except for a declared emergency
- If you have an ADVANCED DIRECTIVE, please bring a copy with you on the day of your procedure. It is the policy of the surgery center that in the absence of an Advance Directive, if there is deterioration in the patient's condition during treatment, the personnel at the surgery center will initiate resuscitative or stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

EGD Prep instructions

Failure to adhere to the following instructions may result in and the need to reschedule your test.

Three days before procedure

o If you are having a pH Bravo test, which you would have received additional paperwork for, DO NOT take any antacids or any medications for reflux or heartburn three (3) days prior to your test.

The day before procedure:

1. No alcoholic beverages

2. DO NOT smoke, vape, smoke marijuana, use tobacco, chew tobacco or use any other recreational drugs after midnight

3. DO NOT EAT, DRINK, CHEW GUM OR HAVE HARD CANDY AFTER MIDNIGHT.

*If your arrival time is scheduled....

Before 12-NOON: DO NOT eat or drink anything after midnight

After 12-NOON: DO NOT eat any solid food after midnight

You may have a clear liquid breakfast BEFORE 7am that morning, but NOTHING

AFTER 7am to eat or drink

Clear Liquid Examples

• Gatorade (NOT RED)

Coffee (NO CREAM)

• Tea or water

Broth or boullion

• Soft drinks (Sprite, 7up)

• Jello (NOT RED)

• Juice (apple, white grape)

• Popsicles (NOT RED)

^{**}Please carefully read the following page about your medications**

About Your Medications (Read at least 1 week before test)

Do Not Take any Iron, Carafate or Sucralfate during your prep or the day of your exam.

• If you take Blood thinners and/or vitamins : SEE BELOW

• Asthma or COPD: please bring your inhaler with you on the day of your procedure.

- Take your blood pressure medications, seizure medications and/or inhalers the morning of your procedure with enough sips of water to completely swallow them at least 2 hours prior to your arrival time
- If you have Diabetes:
 - o DO NOT TAKE any diabetic oral agent the morning of your procedure.
 - o Please bring your diabetic medication or insulin with you the day of your procedure

o If you use an insulin pump, DO NOT turn it off; continue basal rate.

 Check your blood sugar the morning of your procedure. Do not take morning dose. After your procedure, if you are eating, take your normal dose of insulin or other diabetic medication.

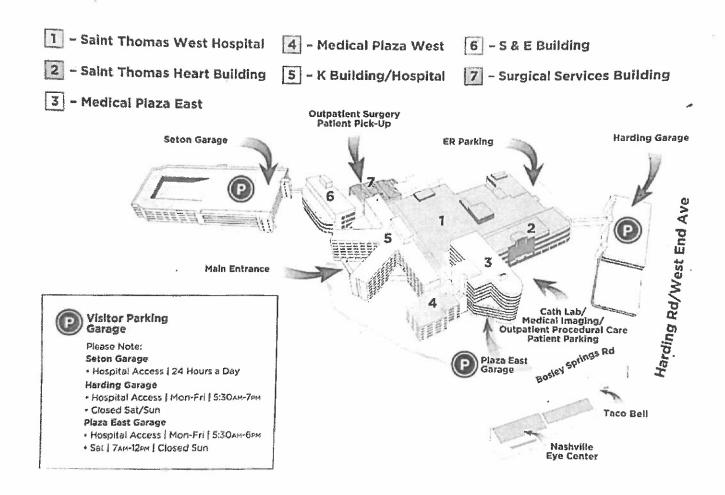
If you take blood thinning medication, herbal supplements or vitamins:

- Blood thinning medications must be stopped or adjusted per the needs of the individual patient.
 This adjustment must be approved by your prescribing physician prior to your procedure.
- If your prescribing physician does not approve of discontinuing your blood thinner, we can
 perform the procedure, but we may not take any biopsies, remove polyps or undertake any other
 therapeutic interventions during your procedure.

Stop or adjust your medications listed below

Medication	Adjustment required	Further Details/Instructions			
Xarelto, Pradaxa, Eliquis, Brillinta	Stop 2 days prior to procedure	Unless prescribing physician instructs NOT to stop			
Effient, Plavix	Stop 7 days prior to procedure	Unless prescribing physician instructs NOT to stop			
Coumadin (Warfarin)	Stop 5 days prior to procedure	Unless prescribing physician instructs NOT to stop			
Aspirin (any medication containing aspirin)	Stop 7 days prior to procedure	Unless prescribing physician instructs NOT to stop			
Stop supplements: Herbal, vitamins, and fish oil	Stop 5 days prior to procedure	1101 to stop			
Ozempic, Mounjaro, Trulicity, Victoza, Rybelsus, Wegovy, or other GLP-1 agonist	Stop 7 days prior to procedure				

THE ENDOSCOPY CENTER OF ST. THOMAS



We are located in St. Thomas Medical Plaza 4230 Harding Pike, Nashville TN 37205

PARKING:

- Park in Medical Plaza East parking garage and take elevators to your designated floor (Third floor for suite 309 or fourth floor for suite 400).
- You may also park in Valet which is located by the Medical Plaza West parking garage.

Patient Medication List

Patient's Name:			DOB:				
			nacy Phone:	Pharm. Address:			
				Revie	wed by R	N:	
Drug Allergy		Reaction		Drug Aller	gy	Reaction	
ease list all medicati	ons: Includir	ig aspirin, blood t	hinners, herbs, y	itamins, sup	plements,	etc. below	
Medication	Dose	Frequency	Last Dose	Continue	FTER DI	SCHARGE (office use)	
2				70000			
					n pi		
	-						
			<u> </u>				
							
ent Signature/:	1		70				
			Date: _				
W medications or	changes to	AFTER	DISCHARGE	D NO -1			
Me	edication	existing inculca	Dose Dose	Frequen		S VISIT Special Instructions	
						- proma and uctivity	
e Signature:			DI	ıvsician Signa	turo:		

Patient History Form

Patient Name:	leight:_		Weight:			DOB:				•	
Race: White/Can	casian	/ Ria	ck-African American	/ His	manio	/Other:					
↓ Ethnicity: Non-F	Iisnanic	:- Latir	o / Hispanic-Latino	/ Dec	lines t	a provide information				_	
Have you had thi What are your sy	s proce	dure b	efore?Yes	No	By Wł	nom?Hov	v long?				
Primary Care Do	ctor:						Dhana.				
Referring Doctor	;						Phone:			-	
General	Yes	_,	Cardiovascular	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	N
Tiredness	1		Dizziness/fainting			Nausea			Muscle weakness		+
Fever		<u> </u>	Chest pain			Rectal bleeding			Implanted device	1	\dagger
Loss of Appetite			Irregular heart beat	·		Vomiting			Dermatologic	Yes	N
Weight Gain			Palpitations			GERD			Allergies		1
Weight Loss			Swelling of ankles			Ulcers	† —	 	Hives	-	+
Hearing loss			Heart failure			Diverticulosis	 		Itching	 	+
Head/Neck	Yes	No	High blood pressure		 	Crohn's	+	 	Yellowing of skin	-	╁
Glaucoma			Heart attack		 	Colitis		 	Rash		
Loss of vision			Heart stents	 	+ -	Hepatitis	 		Open sores	<u> </u>	-
Sinus Problems		Ĭ	Blood clots	+ -	 	Hemorrhoids	+			**	
Endocrine	Yes	No	Pacemaker	-	 	Hiatal hernia	+		Neurologic Seizures	Yes	N
Diabetes	100	710	Defibrillator	 	-	Trouble swallowing	+		Stroke		
Thyroid Disorder			Coronary artery			Genitourinary	Yes	No	TIA		
Respiratory	Yes	No	Heart valve Disease			Dark urine			Neuropathy		
Asthma with frequent inhaler use			Peripheral Vascular Disease			Difficulty urinating			Migraines		
COPD/Emphysema			High Cholesterol			Recurrent UTI			Seizures		
Shortness of breath			Gastrointestinal	Yes	No	Blood in urine	\vdash		Tremor		
Sleep Apnea			Abdominal swelling			Urinate frequently			Vertigo		
Use CPAP/BiPap			Anal/rectal pain			Dialysis			Fibromyalgia		
Home Oxygen use			Abdominal pain			Kidney failure	† · · · · · · · · · · · · · · · · · · ·		Psychiatric	Yes	Ma
Pneumonia			Change in bowel habits			Kidney Disease			Bipolar	168	No
Hematology	Yes	No	Constipation	-		Musculoskeletal	Yes	No	Schizophrenia	-	
Blood thinners			Diarrhea			Chronic Pain	- 40	110	PTSD		
Blood disorder			Colostomy			Gout			Anxiety		
Anemia			Heartburn/ Reflux			Arthritis	-	-+	Depression		
Bleed easily			Incontinence of stool			Back/Neck pain			Sleep Disturbances		
emale Patients:	Last me	enstrua				Any chance of pregnar	new?				
ease list all previous						. my chance of pregnat	iicy i		Type of Birth control:		
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2.)			5.)				7.)				
3.)			6.)				8.)				
							9.)				
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lon Cancer	Se		lother Father Siste lother Father Siste			Daughter Son Ar	nount p	er day	? How Long	??	> 1 T.
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ncreatic Cancer	Se		other Father Siste			Daughter Son An	nount p	er day.	? How long	?	
her Cancer	Se		other Father Siste			Daughter Son Do	you do	recre	ational drugs? Yes	/No	
oe of Cancer:						W.	hat typ	e?			
y Other Medical (Conditi	ons Y	ou May have:								

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to The Endoscopy Center of St. Thomas, my treating physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of the Center, my treating physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my treating physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at The Endoscopy Center of St. Thomas may have an ownership interest in The Endoscopy Center of St. Thomas. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I declined. I wish to have my procedure/services performed at The Endoscopy Center of St. Thomas.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the center is correct.

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize The Endoscopy Center of St. Thomas, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchanged information, health care coverage, care follow-up, and other healthcare information.

Patient Signature	Date Signed	Printed Name
Patient/Guardian Signature (if patient is a minor)	Date Signed	Printed Name
Contact Information: Mobile Phone Number:	E	mail Address:
To revoke your consent to receive text messages or elereplying and entering "Unsubscribe". If you would like center directly in writing or by telephone.		
PATIENT RIGHTS/A I have received written and verbal notification regardi	ADVANCED DIRECTIVES Ing my Patient Rights prior to m	
information regarding policies pertaining to ADVANO Directives along with official state documents have be	CED DIRECTIVES prior to the	procedure. Information regarding Advance
Do you have an Advanced Directive for healthcare	? Yes/No (Circle) If no, would	you like any information? Yes/No (Circle)
The Undersigned certifies that he/she has read and und	lerstands the foregoing and full	y accepts all terms specified above
Signature of Patient or Responsible Party		Print Name
Relationship to Patient		Date Signed

Billing Procedures for The Endoscopy Center of St. Thomas

The Endoscopy Center of St. Thomas Billing Office will inform you of any deductible and co-pays you may own at the time of service. We accept a wide variety of payment options including cash, check, MasterCard and VISA. It may also be possible to make other financial arrangements if you are unable to make payment in full at the time of service.

NOTE: You will receive at least three separate statements for your procedure.

- 1. One of the statements will be addressed from St. Thomas Medical Group/ADI. This bill is a result of the professional services provided to you. This is the fee the doctor has charged for doing the procedure. Our office will bill your insurance company for the charges. However, during this time period, you will continue to receive a statement. Please make arrangements to pay the portion that is not covered by your insurance company as soon as you receive your first statement. Once your insurance company has paid, it will be reflected on your next statement.
- 2. Another statement will be addressed from the Endoscopy Center of St. Thomas. This bill is a result of the facility fee and takes the place of an outpatient hospital bill. The facility is state license and certified by Medicare as an Ambulatory Surgery Center. Your insurance company will be billed separately for these charges. However, during this period, you will continue to receive a statement. Please make arrangements to pay the portion that is not covered by your insurance company the day of service. Once your insurance company has paid, it will be reflected on your next statement.
- 3. The third bill will be from IMG Anesthesia or Nashville Gastro Anesthesia (NGA) for the anesthesia provided during your procedure.
- 4. There may be other statements sent to you by a lab and pathologist due to biopsies obtained during your procedure. Their billing procedures may differ from the three above. You will need to contact the number on your statement for any questions you may have regarding their billing procedures.

read and understands the above and fully acce	pts the terms specified
Printed Name	¥1

Signature of Patient / Guardian

NASHVILLE GASTROINTESTINAL SPECIALIST, INC.

Howard Mertz, MD, FACG

Patient or Patient Representative Signature

Edward A. White MD

Steven Delaney MD

FELLOWS OF AMERICAN COLLEGES
OF PHYSICANS & GASTROENTEROLOGY
DIPLOMATES OF A.B.L.M.
SUBSPECIALTY OF GASTROENTEROLOGY

By my signature below, I acknowledge I have received a copy of Nashville Gastrointestinal Specialist, Inc.'s Notice of Privacy Practices concerning my protected healthcare information. Date Patient Name (Printed) Patient or Patient Representative Signature I authorize the following individuals to receive information about my health status, which may include information about my protected healthcare information. Date of Birth Relationship Print Name Date of Birth Relationship Print Name Relationship Date of Birth Print Name I authorize Nashville Gastrointestinal Specialist, Inc. will only release my protected healthcare information to the individuals that I have indicated on this form. All other requests for protected healthcare information must be made in accordance with the Nashville Gastrointestinal Specialist, Inc. HIPAA Policy and Procedures Manual concerning the privacy of my protected healthcare information. Date Patient Name (Printed)