PCS
PRIMARY CARE SPECIALISTS
PROCEDURE SUITE

Mark L. Mansfield, MD

UPPER ENDOSCOPY

Your physician has determined that upper endoscopy is necessary for further evaluation or treatment of your condition. This brochure has been prepared to help you understand the procedure. It includes answers to questions patients ask most frequently. Please read it carefully. If you have additional questions, please feel free to discuss them with the nurse or your physician before the examination begins.

WHAT IS UPPER ENDOSCOPY?
Upper endoscopy (also known as endoscopy, an upper GI endoscopy, esophagogastroduodenoscopy, EGD) is a procedure that enables your physician to examine the lining of the upper part of your gastrointestinal tract, i.e. the esophagus (swallowing tube), stomach, and duodenum (first portion of the small intestine) using a thin flexible tube with its own lens and light source.

WHY IS UPPER ENDOSCOPY DONE?
Upper endoscopy is usually performed to evaluate symptoms of persistent upper abdominal pain, nausea, vomiting, or difficulty swallowing. It is also the best test for finding the cause of bleeding from the upper gastrointestinal tract. Upper endoscopy is more accurate than X-rays for detecting inflammation, ulcers, or tumors of the esophagus, stomach and duodenum. This is particularly true when there has been a major operation on the upper gastrointestinal tract. Upper endoscopy can detect early cancer and can distinguish between benign and malignant (cancer) conditions by performing biopsies (taking small tissue samples) of suspicious areas. Biopsies are taken for many reasons and do not necessarily mean that cancer is suspected. Upper endoscopy is also used to treat conditions present in the upper gastrointestinal tract.

WHAT CAN BE EXPECTED DURING THE UPPER ENDOSCOPY?
Your doctor will review with you why upper endoscopy is being performed, whether any alternative tests are available, and possible complications from the procedure. You will have your throat sprayed with a local anesthetic before that test begins and will be given medication through a vein to help you relax during the test. While you are in a comfortable position on your side, the endoscope is passed through the mouth and then in turn through the esophagus, stomach, and duodenum. The endoscope does not interfere with your breathing during the test. Most patients consider the test to be only slightly to not at all uncomfortable and many patients fall asleep during the procedure.

WHAT HAPPENS AFTER UPPER ENDOSCOPY?
After the test you will be monitored until most of the effects of the medication have worn off. Your throat may be a little sore for awhile, and you may feel bloated right after the procedure because of the air introduced into your stomach. You will be able to resume your diet after you leave the procedure area unless you are instructed otherwise. In most circumstances your doctor can inform you of your test results on the day of the procedure; however, the results of any biopsies or cytology samples taken will take several days.

WHAT ARE POSSIBLE COMPLICATIONS OF UPPER ENDOSCOPY?
Endoscopy is safe. Complications can occur, but are rare when the test is performed by physicians with specialized training and experience in this procedure. Bleeding may occur from a biopsy site or where a polyp was removed. It is usually minimal and rarely requires blood transfusions or surgery. Localized irritation of the vein where the medication was injected may cause a tender lump lasting for several weeks, but this will go away eventually. Applying heat packs or hot moist towels may help relieve discomfort. Other rare but potential

risks include an anaphylactic or allergic reaction, respiratory suppression, low oxygen, arrhythmia, myocardial infarction or pneumonia due to the sedatives used. A missed diagnosis must also be considered. Major complications, e.g. perforation (a tear that might require surgery for repair) are very uncommon. They occur less often than once in 10,000 tests. It is important for you to recognize early signs of any possible complication. If you begin to run a fever after the test, have trouble swallowing or have increasing throat, chest or abdominal pain, let your doctor know promptly.

TO THE PATIENT
Because education is an important part of comprehensive medical care, you have been provided with this information to prepare you for this procedure. If you have any questions about your need for upper endoscopy, alternative tests, the cost of the procedure, methods or billing, or insurance coverage, do not hesitate to speak to your doctor or doctor's office staff about it. Most endoscopists are highly trained specialists and welcome your questions regarding their credentials and training. If you have questions that have not been answered, please discuss them with the nurse or your physician before the examination begins. If you are referred from another physician and have not met with Dr. Mansfield, please schedule an appointment to discuss the need, treatment options, and nature of the procedure.

ENDOSCOPY PREPARATION INSTRUCTIONS

Be sure to discuss with the doctor whether you should adjust any of your usual medications before the procedure, any drug allergies you may have, and whether you have any other major diseases such as a heart or lung condition that might require special attention during the procedure. The preparation for an EGD is very simple. The following are your instructions:

1. *Notify your nurse and doctor if you need pre-procedure antibiotic prophylaxis for any reason.*
2. *Do not take iron preparations for 3 days prior to the exam.*
3. *<u>Continue</u> all other medication that you are taking. If you are taking blood thinners, insulin or diabetes pills, get special instructions from your doctor. Push fluids. Please notify the staff if you are taking any tranquilizers if we did not discuss these while planning your test.*
4. *The day before your procedure:*
    a. ***Do not** drink milk or milk products*
    b. ***Do not** eat red or orange Jell-O*
    c. ***Do not** use any antacids or stomach medications unless otherwise advised*
    d. ***Do not** eat after 10 p.m. You may have a few ice chips or sips of water only before bedtime*
5. *Eat a light supper the evening before the exam.*
6. *It is okay (and encouraged) to use toothpaste the morning of the procedure! Coffee or tea is okay the day before your procedure; but not the morning of your procedure.*
7. *If you are scheduled at the hospital, **you <u>must</u> arrive 60 min. before** the procedure to allow time to begin an IV to receive the medicine for sedation. **You only need to arrive 15 min early if it is scheduled at The PCS Procedure Suite.***
8. *Please make arrangements for someone to drive you home after your procedure.*
9. *Please check in for your procedure through the Procedure Suite door!*

Get a good night's sleep and be reassured about this procedure. It is not usually difficult at all. Most patients have no real discomfort. Please ask your helper to read these instructions. Most people nap for 1 to 3 hours following EGD and are then fine. You should not drive or do anything delicate or dangerous for 12 hours after the procedure because of the medicines used to quiet the gag reflex. Do not drink any alcoholic beverages for 8 hours after this procedure.

CONSENT FOR ENDOSCOPY (EGD) WITH POLYPECTOMY AND/OR BIOPSIES

This consent form refers to risks and possible consequences, which may result. We are concerned mainly with perforation of the digestive tract and with hemorrhage. Perforation means to punch a hole in the esophagus, stomach or duodenum. If this should occur an immediate operation would probably be necessary. You would be put to sleep with a general anesthetic, your abdomen would be opened and the perforation would be closed. The risk of perforation is quite small, less than one in several thousand procedures. Other rare but potential risks include an anaphylactic or allergic reaction, respiratory suppression, low oxygen, arrhythmia, myocardial infarction or pneumonia due to the sedatives used. A missed diagnosis must also be considered. Risks of anesthetics as described, although rare, are very real. Hemorrhage means the occurrence of important bleeding following the procedure, as from biopsy sites or from injury occurring during passage of the instrument. In cases where bleeding has occurred, it has almost always stopped by itself. Rarely, blood transfusion has been required. In very rare cases, an operation has been necessary to control the bleeding. The risks of important hemorrhage are also quite small, less than one in several thousand procedures. When we consider the risks and possible complications of any manipulative procedure, we must also consider the extreme possibility of death occurring during or close to the time of the procedure. This is an extremely rare occurrence in connection with the procedures we are discussing. It is mentioned mainly for completeness so you may be fully informed when you sign your consent form. As you might imagine, we do not expect any of these events to happen during your procedure, but you must be aware of the possibilities.

As stated, please read our upper endoscopy brochure prior to signing this consent for additional information. You are advised not to drive an automobile, operate mechanical equipment or engage in hazardous activity for 12 hours following the procedure because of the sedative effect of the medicines to be given. Have a responsible person pick you up, drive you home and see you are in responsible company for the rest of the day.

1. *I hereby authorize performance of the procedure called **FLEXIBLE ESOPHAGOGASTRODUODENOSCOPY WITH POSSIBLE BIOPSIES AND/OR POLYPECTOMY** under the direction of Mark L. Mansfield, M.D. and/or such assistants he may designate.*
2. *I have been made aware of certain risks and consequences that may be associated with the procedure described above.*
3. *It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure and/or different procedure(s) than those set forth in this consent form. I therefore authorize and request that Mark L. Mansfield, M.D. and his designated assistant(s) perform such procedure(s) as are necessary and desirable in the exercise of professional judgment, to include the administration of blood transfusion, should immediate need occur. The authorization granted under this paragraph shall extend to treating all conditions that require treatment and are not known to Mark L. Mansfield, M.D. at the time the procedure commences.*
4. *I hereby consent to the administration of such anesthetics and or other medication as may be considered necessary or advisable by the physician responsible for this service.*
5. *I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of the procedures.*
6. *I also acknowledge I have been informed of alternatives to this procedure and understand those alternatives.*

*Patient Name*_____ *DOB* _____

Patient Signature _____

Date _____ *Time* _____

*Parent or Guardian Name (if patient is a minor)*_____

Parent or Guardian Signature _____

Date _____ *Time* _____ *Relationship* _____

Witness Signature _____

Form approved 8/6/2015

PCS Procedure Suite

(Procedures done in our procedure suite are not considered 'in office' procedures. When contacting your insurance for prior authorization, please let them know the procedure will be performed in an ambulatory surgery center and make sure that your insurance is in network with our ambulatory surgery center.)

Consent for admission and treatment at PCS Procedure Suite

Your physician has recommended you have a procedure, by signing this form you CONSENT TO and AUTHORIZE such procedure to be performed at PCS Procedure Suite. In addition, this consent covers any necessary anesthesia, pathology, laboratory procedures and emergency treatment, while inside PCS Procedure Suite.

The undersigned acknowledges and understands that no guarantee or assurance has been given as to the results which may be obtained.

Assignment of Insurance Benefits

In the event the patient is entitled to insurance benefits for the procedure being performed, said benefits are hereby assigned to PCS Procedure Suite. All disputes regarding coverage are between you and your insurance carrier. The undersigned and/or the patient shall assume all responsibility for charges not covered or deemed patient responsibility, by their insurance. If the undersigned does not have current insurance coverage, he/she accepts full responsibility for all charges incurred.

Release of Information

PCS Procedure Suite may disclose all or any part of the patient's records to any party that is or may be liable under a contract for all or part of PCS Procedure Suite charges. These may include: insurance companies, third party administrators, contract providers, or the patient's employer (in cases of worker's comp). Patient records will not be released to unauthorized individuals.

Financial Agreement

The undersigned, whether he/she signs as agent or as the patient, understands and agrees that upon admission to PCS Procedure Suite, the patient enters into a contract for payment of services rendered to him/her. This document constitutes a **BINDING CONTRACT** between the two parties. The undersigned agrees that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself and if married obligates his/her marital partner, to pay the account of PCS Procedure Suite, Inc. in accordance with its regular terms and rates. PCS Procedure Suite will charge interest at a rate of 18% per year on any delinquent balances.

Statement to Permit Payment of Medicare to PCS Procedure Suite, Inc.

The undersigned requests payment of authorized Medicare Benefits to he/she on his/her behalf for any services furnished to the patient by or in PCS Procedure Suite. The undersigned authorizes PCS Procedure Suite to release to Medicare, CMS Administration or any of its intermediaries, carriers or agents, any information needed to determine these benefits or benefits for related services.

By signing below, I have read the information above and I choose to have my procedure performed at PCS Procedure Suite. I understand that Dr. Mansfield has ownership in PCS Procedure Suite, that PCS Procedure Suite is a separate entity from Primary Care Specialists. I will receive a bill from PCS for the doctor's service. I will receive a separate bill from PCS Procedure Suite, which covers the use of the facility, equipment, and supplies. I also understand that if I choose not to have my procedure done at PCS Procedure Suite, arrangements can be made at another facility, at my request.

THE UNDERSIGNED HAS READ, FULLY UNDERSTANDS, AND AGREES TO ALL OF THE ABOVE PROVISIONS AND INFORMATION IN THIS DOCUMENT.

_____ _____

Name (Print) **DOB**

_____ _____

Signature: Patient/Parent or Legal Guardian **Legal Relationship to Patient**

_____ _____ _____

Date **Time** **Address**

_____ _____

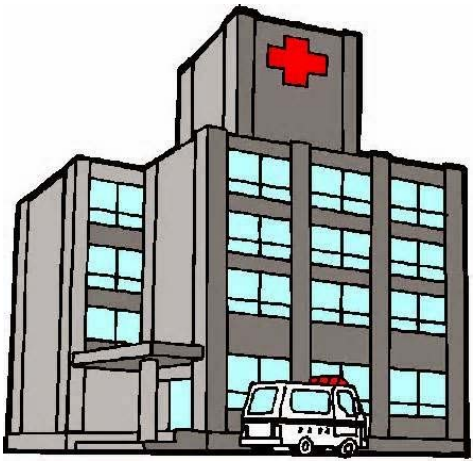
Home # & Work # **Witness**

Form approved 8/6/2015

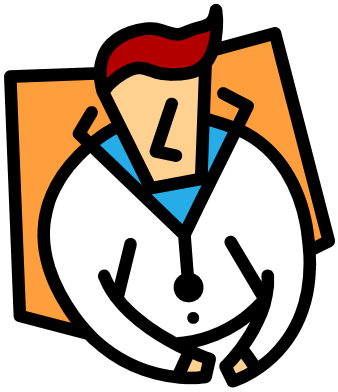
Billing for your Procedure

Total Cost of Your Procedure

2 Separate Bills



Medical Facility's Fee
PCS Procedure Suite



Physician Fee

The total cost for many medical services may be comprised of two fees. Each fee will be billed separately.

The medical facility fee (PCS Procedure Suite) covers the cost of the equipment and supplies involved in the performance of your service.

The physician's fee is for services provided by your physician or the actual procedure.

PCS PROCEDURE SUITE, INC.
Patient Rights and Responsibilities

Patient Rights

PCS Endoscopy Suite encourages respect for the personal preferences and values of each individual and supports the *Rights* of each patient of the Endoscopy Suite, or their designated representative as follows:

- The right to considerate and respectful care.
- The right to ask for and receive relevant, current, and understandable information concerning their diagnosis, treatment and prognosis from their physicians and other direct caregivers.
- The right to consent or refuse a treatment, as permitted by law, and in case of such refusal, the right to other appropriate care and services that the Endoscopy Suite provides or transfer to another facility.
- The right to have advance directives.
- The right to every consideration of privacy during consultation, examination and treatment.
- The right to expect all communications and records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to review their own records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to expect that, within its capacity and policies, the Endoscopy Suite will make a reasonable response to a request for appropriate and medically-indicated care and services, including evaluation, service and/or referral as indicated by the urgency of the case. If transfer is recommended and requested, the patient will be informed of risks, benefits, and alternatives, and will not be transferred until the other institution has indicted acceptance.
- The right to ask and be informed of the existence of business relationships among PCS Endoscopy Suite, educational institutions, other health care providers, or insurers that may influence the patient's treatment and care.
- The right to consent or decline to participate in research affecting care or requiring direct patient involvement, and if such participation is declined, to be entitled to the most effective care PCS Endoscopy Suite can otherwise provide.
- The right to be informed of realistic alternatives to care at PCS Endoscopy Suite.
- The right to be informed of PCS Endoscopy Suite policies and practices that relate to patient care and treatment, including charges for services and payment methods, and to be informed of available resources for resolving questions and concerns about care and treatment.

Patient Responsibilities

The collaborative measure of healthcare requires that patients participate in their care by fulfilling certain *Responsibilities*. Patients and/or families or designated representatives are responsible for:

- Requesting additional information or clarification about their health status or treatment when information or instructions are unclear.
- Ensuring that PCS Endoscopy Suite has a copy of their updated demographic information, should you need to be contacted.
- Informing physicians and other caregivers if there are problems in following prescribed treatment.
- Treating other patients, physicians, caregivers and staff with consideration and respect and recognizing that alternative care may be recommended if patient's, patient's representative or patient's family's behavior is considered unreasonably disruptive.
- Providing necessary information for insurance claims and for working with PCS Endoscopy Suite to make payment arrangements, when necessary.
- Show respect and consideration for meeting financial commitments.
- Recognizing the impact of their lifestyle on their personal health.
- Providing information about past illnesses, hospitalizations, medications, pertinent family history, and other matters related to health status.

You should expect to receive the highest quality of care at PCS Endoscopy Suite. Should you have any questions or concerns, please direct them to the facility manager on site. We appreciate constructive criticism and strive to improve our services whenever possible.

Complaint Resolution & Grievance Process

During your procedure, you and your family are encouraged to discuss questions about your care and the ASC environment with personnel and your physician. These individuals will assist in resolving issues or concerns.

If the patient or family member has a concern that is not promptly resolved after speaking with staff present, they may file a grievance. The grievance may be written or verbal and should be directed to:

Administration, PCS Endoscopy Suite
110 Vista Drive
Pocatello, ID 83201
208-234-0024 (#107)

A written response to each grievance will be provided to the patient or their representative within 14 days and will include the steps taken to investigate the grievance, the date the grievance process was completed and the name of an ASC contact person.

A patient or family also has the right to file a grievance with the following agency:

The Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705
208-334-6626

You may also find support through a Medicare Ombudsman at the following website:
http://www.medicare.gov/navigation/help-and-support/ombudsman.aspx

Advance Directives

updated 9/14/12

In addition to having the right to have your medical treatment options explained to you by your physician, you have the right to accept or refuse medical treatment and the right to have your advance medical directives explained to you for a situation where you become incapacitated or unable to communicate. Under Federal Regulations, PCS Endoscopy Suite will provide this information to each patient, however, it is the policy of PCS Endoscopy Suite as an outpatient facility, not to carry out Advanced Directives. Rather, the patient will be stabilized and transported to the nearest emergency facility where the Advance Directives will be followed.

Advance Directives are documents, which indicate your choices for future health care. The purpose of advance directives is to give you more control over your medical care, ensuring that physicians and family members have no doubt about how much life-prolonging technology you would want.

There are three kinds of advance directives:

- Living Will
- Durable Power of Attorney
- POST (Physician Orders for Scope of Treatment)

LIVING WILL:

If you are 18 years of age and of sound mind, you may complete a *Living Will* which describes your preferences for life-sustaining treatment. Idaho's *Living Will* allows you to specify one of the following options should you become terminally ill and unable to communicate your wishes:

- That all medical treatment and care, including nutrition and hydration, necessary to restore or sustain your life, be provided to you.
- Those artificial life-sustaining procedures be withheld or withdrawn *with* the exception of nutrition and hydration.
- Those artificial life-sustaining procedures be withheld or withdrawn *including* nutrition and hydration.

The *Living Will* takes effect ONLY if your physician believes you are permanently unconscious or that death is near, AND you are unable to tell others your wishes. You may cancel your *Living Will* at any time, as long as you are of sound mind. A *Living Will* requires two witnesses to your signature, but does not have to be notarized.

DURABLE POWER OF ATTORNEY:

If you are at least 18 years of age or older and of sound mind, you may complete a Durable Power of Attorney which designates an individual to be your health care agent (or surrogate) to make health care decisions for you if you lose the ability to make decisions yourself. The individual you select as your health care agent should be someone who understands the kind of medical treatment you do and do not want. You may also designate an alternate to act for you if the first person you designate is unable to

act as your agent. As long as you are of sound mind, you may cancel your Durable Power of Attorney and make a new one.

A Durable Power of Attorney goes in effect ONLY if you are unable to make your own health care decisions. A Durable Power of Attorney does not have to be notarized, but there are restrictions on who can serve as your health care agent, as well as who can witness the document.

POST (Physician Orders for Scope of Treatment):

POST is a document completed by a patient and authenticated by their physician. This form is registered with the State and available online at http://www.sos.idaho.gov/general/hcdr.htm. This document transcends institutions and may follow a patient from one setting into the next. This is a supplement to other advance directives. This document replaces the former Idaho DNR Orders.

For more information on Advance Directives or assistance in completing these documents, contact the Registered Nurse on staff at the facility.