COLONOSCOPY INSTRUCTIONS
PM PROCEDURE (Check in time 11:30am and 2:15pm)

REVIEW these instructions **7 days** & **2 days** before your procedure to ensure adequate preparation.

Pick up your bowel prep prescription from your pharmacy at least 5 days before your procedure.

We will notify you 3 days before your procedure of your **ARRIVAL TIME ONLY** this is not your procedure time.

1. **CLEAR LIQUIDS ONLY THE ENTIRE DAY BEFORE YOUR PROCEDURE FROM THE TIME YOU WAKE UP.** DO NOT have anything **RED or PURPLE**. **No Solid foods, Milk or Dairy products**

   Drink plenty of clear liquids for adequate hydration, nutrition and improved prep results include: Orange Soda, Ginger Ale, Sprite, 7Up, Apple Juice, White Grape Juice, Lemonade, Black/Green Tea, Coffee (no creamer) Tang, Crystal Light, Kool Aid, Popsicles (no fruit/sherbet), Jello (no fruit/toppings), Beef/Chicken or vegetable soup broth, Gatorade, Powerade (Clear Protein Drinks: Ensure clear Apple, Isopure/Cytosport/Premier Protein

2. **Trilyte/Golyte/PEG (1 Gallon Jug):** In the AM Add water to jug, shake well, put in fridge to chill.

3. **START BOWEL CLEANSING PRESCRIBED PREP at 6:00 PM** the night before your procedure
   FOLLOW THESE INSTRUCTIONS ONLY; DO NOT FOLLOW INSTRUCTIONS ON THE BOTTLE OR BOX

   **** If you have received a different bowel cleansing prep please contact the office for instructions in you have not received by the office at the time of scheduling:** Clenpiq, MoviPrep, Osmoprep or HalfLytley

   SUPREP (2 Bottles in Box)

   a. Pour **ONE** (1) 6-ounce bottle of SUPREP liquid into the mixing container. Add water to the 16-ounce line on the container and mix. Drink all the liquid in the container.
   b. You **must drink two (2) more 16-ounce containers** of water over the next 1 hour.

   Trilyte, Golyte, PEG (1 Gallon Jug)

   c. Drink one glass every 10-15 minutes until ½ the jug is gone. Refrigerate remainder.

4. You may continue to drink clear liquids after completing first half of bowel prep.

1. **SIX (6) HOURS BEFORE YOU CHECK IN BEGIN SECOND HALF BOWEL PREP**

   SUPREP (2 Bottles in Box) Bowel Prep –

   - Pour **ONE** (1) 6-ounce bottle of SUPREP liquid into the mixing container. Add water to the 16-ounce line on the container and mix. Drink all the liquid in the container.
   - You **must** drink two (2) more 16-ounce containers of water over the next 1 hour.

   Trilyte, Golyte, PEG (1 Gallon Jug): Drink one glass every 10-15 minutes until gone.

2. You may continue drinking **CLEAR LIQUIDS** the morning of your procedure up until **4 hours** before your arrival time.
3. **ABSOLUTELY NO WATER, Gum, Mints or Hard Candy** within 4 Hours of your arrival time.
4. **Heart, Blood Pressure, Seizure Meds: Take these medications if usually taken in the AM.**
   ** If you are diabetic and check your blood sugars, please check your BS before coming in.

PLANNING FOR YOUR PROCEDURE

- **Fill your Prescription within the next 5 days.** It may have been sent electronically to your Pharmacy.
- **CONFIRMING YOUR PROCEDURE: If you HAVE NOT heard from the Endoscopy at least 5 days before your procedure date call (951) 304-0200.** We will make every attempt to reach you, if we can't contact you with the information you have provided, we will cancel your scheduled procedure.
- **$100.00 Cancellation Fee - See specific financial policy you signed at time of scheduling****
- **YOU MAY NOT DRIVE YOURSELF OR USE UBER/LYFT - see transportation policy attached.** Your driver must check in with you and may be required to stay in the facility depending on the time of your procedure. If they leave, we will need a cell phone number to call them to return to the center within 20 minutes of the call.
- **You will you will be at the Endoscopy Center for approximately 1.5 to 3 hours**. The length of stay is based on many variables beyond our control, such as poor prep, findings & necessary interventions. Rest assured we will not rush through your exam just to stay on schedule. Upon checking in we will give an updated estimate.
- Wear comfortable clothing; **DO NOT wear jewelry**, perfume or lotions. **Leave valuables at home**.
- **Bring your Completed Medication Record (included in instruction packet) & your Co-pay**. *If you did not preregister with the center in person bring Insurance card & photo ID.*

7 DAYS PRIOR TO PROCEDURE REVIEW YOUR INSTRUCTIONS AND DO THE FOLLOWING

- **Stop taking iron pills or vitamins containing iron 7 days prior to your procedure**
- **Stop taking NSAIDS (Nonsteroidal Anti-inflammatory medications) 7 days before your procedure:** Examples: Mobic, Motrin, Advil, Aleve, Ibuprofen, Celebrex, Indocin, Toradol, Orudis, Relafen, Naprosyn, Naproxen, Feldene, Excedrin w/ aspirin, etc.
- **ASPIRIN:** Follow specific instructions given below by your GI physician and/or the Procedure Scheduler if you are taking a daily aspirin prescribed by your physician.
  ** If you are taking Aspirin occasionally just for pain relief only stop taking 7 days before your procedure.

DIABETIC or BLOOD THINNING MEDICATION

- **DIABETIC PATIENTS – DO NOT TAKE Oral Diabetic Medication the NIGHT BEFORE and THE MORNINIG of your scheduled procedure** (Januvia, Glyberide, Glimiperide, Metformin, Actos, Glucotrol, Glipizide, Byetta, Avandia, Diabinese, Micronase, Diabeta, Amaryl, Prandin, Starlix, Glucophage, Pecrose, Glyset)
- **INSULIN DEPENDANT DIABETIC PATIENTS – Take ONLY ½ dose of insulin the night before your procedure and DO NOT take the morning of your procedure,** unless otherwise instructed by our office. * For pump or brittle diabetics check with your Primary Care or Endocrinologist for specific instructions. (Humulin, Lantus, Novolin, Humulog, etc)
- **BLOOD THINNERS – Notify us immediately** if you are taking Plavix (clopidogrel), Xarelto (rivaroxaban), Eliquis (apixaban), Pradaxa (dabigatran), Coumadin**, Warfarin**, Jantoven, Brilinta (Ticagrelor), Effient (Prasugrel), Aggrenox, Heparin, Lovenox) **See specific instructions below:

☐ **PT/INR Blood Test:** If this box checked you must have the test in the morning the day before your test.

SUGGESTIONS AND POINTS TO REMEMBER

- **Drink plenty of Clear Liquids the entire day for nutritional value and improved prep results.**
- If you develop discomfort or distention (bloating), wait 20-30 minutes and resume drinking a glass every 15-20 minutes. This will improve once you begin having bowel movements.
- Nausea, cramping and abdominal fullness are the most common adverse reactions. Stay well hydrated to avoid symptoms related to dehydration (headache, weakness, fatigue & lightheadedness).
- Do not add one flavor to entire gallon. Pour part of solution into a smaller container (glass, pint, or quart) prior to adding a flavor packet (crystal light crystals or tang may be used) to vary the flavors.
- Suggestions include drinking each cup quickly, or through a straw. **DO NOT** pour over ice.
- Eating Jell-O or sucking on hard candy after each cup may also help.

FOLLOWING YOUR PROCEDURE

- **Do not drive a vehicle, operate any machinery, or sign legal documents until the following day.**
- It is recommended to have someone stay with you after your procedure for assistance.
- The physician will discuss findings and specific instructions with you and your responsible adult; however, due the sedation given, you may not recall the conversation.
- You will be given specific discharge instructions in writing to review after the sedation has worn off.
- A report will be sent to your primary care physician. If specimens were obtained results usually take 10-14 days to receive. You will be notified of the results and a copy will be sent to your primary MD.
- The Endoscopy Center will call you the business day following your procedure to check on you. If you receive a message you do not need to call back unless you have a question.

For questions regarding the instructions given you may call the physician office at (951) 600-0288 or the Endoscopy Center (951) 304-0200.

If it is after 5 PM the night before your procedure you may call the physician on call for urgent or emergent matters concerning your procedure or colon preparation.

If you received a call from the Endoscopy Center regarding your procedure please return the call between the hours **07:30am to 4:00pm Monday thru Friday** at **(951)304-0200.**

40404 California Oaks Road, Suite A, Murrieta CA 92562
ENDOSCOPY CENTER OF INLAND EMPIRE

FINANCIAL POLICY

It is the goal of the Endoscopy Center of Inland Empire to provide you with the best possible service before, during and after your procedure. The following are general guidelines our facility has established for our patients regarding the center's billing policy. ***Please review the following:***

1. The center will verify eligibility of insurance benefits. Based on your plans benefits you will be notified in advance if you have a Copay, Co-insurance or have not met your deductible. **The amount quoted is for the Endoscopy Only and due at the time of service.** You will also be responsible for any balance remaining once the claim is processed. **We accept Cash, Debit (Visa or MC logo), Credit Cards and Money orders. WE DO NOT PERSONAL CHECKS OVER $50.00.**

2. As a courtesy to our patients, we will file your claim with your insurance company once the procedure is completed. Your insurance company will **process the claim based on the procedure performed and specific findings.** We will notify you of any remaining balance due once the claim is processed. Our relationship is with you, our patient, not your insurance company. Consequently, all charges incurred are your responsibility. If you do not have insurance, arrangements will be made before your procedure, payment is due at the time of service.

3. **SCREENING COLONOSCOPY**: You may have preventative coverage for your colonoscopy, however once the procedure is completed based on the actual findings your insurance company may change the coverage from ***preventive screening covered at 100% to a medical procedure***, ***your deductible or co-pay will then apply***. ***You will be responsible for the balance due***. Contact your insurance plan for clarification regarding coverage.

4. Many carriers require preauthorization which can take time to obtain. If you have Medicare and have signed up with a medical group preauthorization is required therefore you must inform us at the time of scheduling. **It is your responsibility to inform Endoscopy Center of Inland Empire regarding changes in your insurance coverage before your scheduled procedure. Failure to do so will result in cancellation of your procedure.**

5. **Medi-Cal Insurance**: The Endoscopy Center of Inland Empire **DOES NOT participate in the Medi-Cal program**. It is your choice to have your procedure at the center and in doing so you are accepting responsibility for any co-insurance, co-pay or deductible listed under your primary insurance benefits. **This will be due at the time of service**

6. **Out of Network**: It is your responsibility to know your healthcare coverage benefits and should call member services to see if your facility and/or physicians are considered in network providers for your specific plan. Although we may be contracted with a specific insurance company or Medical Group, we may not be an in-network provider under your specific plan within that company and/or Medical Group.

7. Please understand that there are several components to your services and you will receive a separate bill for each service provided. **You will receive at least one** of the 4 listed below based on the findings and insurance coverage.
   - **FACILITY:** This is for the use of the facility for highly trained nursing staff, equipment and medication used during your procedure. This bill will come from Endoscopy Center of Inland Empire, Inc.
   - **PHYSICIAN FEE:** This is the **fee paid to your doctor for performing the procedure only**. This does not include the office visit or consultation fee. This bill will come from Inland Empire Gastroenterology Medical Group, Inc.
   - **PATHOLOGY FEE:** If tissue biopsies are taken, you may receive a bill from an outside Pathology Service
   - **ANESTHESIA FEE:** You may receive a separate bill from ECIE Anesthesia, LLC depending your insurance.

8. **CANCELLATION / RESCHEDULING FEE $100.00**: Procedures cancelled without 3 business days (not including Sat. & Sun.) Due to the time required to verify insurance eligibility and preparation procedures that have rescheduled more than 3 times (within 7 days of procedure) will incur a $100 fee. This must be paid before rescheduling the procedure.

9. While we are pleased to assist you with your insurance, the obligation for payment of our fees remains that of the patient or responsible party. Although we are contracted with many insurance companies, ours may not be within your network and you may be responsible for additional fees than with that of a contracted facility. Please contact your insurance if you are unaware of your individual policy restrictions and benefits. The obligation to assure payment in a timely manner lies with you regardless of what your insurance company chooses to do. Delinquent accounts will be turned over to a collection agency and **YOU** will be responsible for any collection fees incurred.

10. **RELEASE OF INFORMATION**: I hereby authorize Endoscopy of Inland Empire to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which the patient or insured is entitled for my treatment and medical services provided to me, to be paid directly to Endoscopy Center of Inland Empire. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary.

THIS IS A SAMPLE CONSENT FOR REVIEW. YOU WILL BE ASKED TO SIGN A CONSENT THE DAY OF YOUR PROCEDURE.

ENDOSCOPY CENTER OF INLAND EMPIRE SAMPLE CONSENT

Planned Procedure/s and Possible Complications

☐ **Colonoscopy:** Possible complications may include but are not limited to: Bleeding, infection, perforation, splenic injury, missed lesion and any additional risks that may be discussed with me by my physician.

☐ **Esophagogastroduodenoscopy:** Possible complications may include but are not limited to bleeding, infection, perforation, damage to teeth or dental work, missed lesion and any additional risks that may be discussed with me by my physician.

☐ **Flexible Sigmoidoscopy:** Possible complications may include but are not limited to rectal bleeding, infection and/or shock secondary to rectal bleeding, missed lesion and any additional risks that may be discussed with me by my physician.

Anesthesia Types and Complications

☐ **Deep Sedation:** Including an unconscious or semi-conscious state with some degree of arousal, occasional purposeful movement. The use of a breathing tube in the windpipe and other airway devices is unlikely. Intravenous medications will provide most of the anesthesia. Risks include mouth or throat pain, hoarseness, injury to mouth or teeth, awareness of intraoperative events, injury to blood vessels, aspiration, and pneumonia.

☐ **Monitored Anesthesia Care (MAC):** Semi-conscious state with some degree of arousal, occasional purposeful movement. The use of a breathing tube in the windpipe and other airway devices is unlikely. Some of the more common complications of sedation include: increase or decrease in heart rate and blood pressure, difficulty breathing, allergic reaction (rash, itching) to medication and/or nerve damage/phlebitis at the IV site. Although rare, unexpected severe complications may occur including difficulties breathing, cardiac arrest and death.

☐ **Moderate Sedation/Analgesia ("Conscious Sedation"):** A drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

I authorize the diagnostic procedure(s) and such other therapeutic procedure(s) which may be necessary, including, anesthesia care and pathology. I understand and agree that the persons administering anesthesia or performing other professional services, such as pathology and the like, are independent contractors and may not be employees or agents of the attending physician or the facility. I acknowledge and understand that the following procedure which has been described to me is to be performed at Endoscopy Center of Inland Empire (the "Facility"):

(A) Understanding of the Procedure: I understand the nature of the procedure, the expected benefits or effects of such procedure, the medically acceptable alternative procedures or treatments. I have a general understanding of the procedure to be performed on me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

(B) Possible Risks of The Procedure(s): I understand and consent to the possible complication of the scheduled procedure as they have been explained to me.

(C) Consent for the Administration of Anesthesia: In addition to the foregoing, I consent to the administration of Anesthesia as required for the procedure. I understand and acknowledge that all forms of anesthesia involve some risks and the facility can make no guarantees or promises concerning the results or outcome of the anesthesia plan of care. I acknowledge that I have made arrangements to have a responsible person to drive me home after the administration of anesthesia. I acknowledge that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and I will avoid making decisions or taking in activities, which depend upon full concentration or judgment during this period. If you have ever had a severe allergic reaction to ANY substance or environment (including latex or a bee sting) you must tell your physician and the anesthesia provider before we give you medication or other substances. I understand the possible complication of the planned anesthesia care as they have been explained to me.

(D) Pregnancy Testing: I request and consent to the Facility performing a urine pregnancy test, as part of the Facility's routine pre-operative lab work due to the possible risks of anesthesia and certain medications to a fetus, including birth defects and miscarriage. I understand a urine pregnancy test is generally accurate, but no pregnancy test is 100% reliable, and there is a possibility this test could miss an early pregnancy or have a false positive result. *If the Patient you believe that you might be pregnant, it is your responsibility to notify the attending physician and anesthesia provider before any medication or anesthesia is given.*

(E) Human Immunodeficiency Virus (HIV) and Hepatitis Testing: I understand that in the event a health care worker sustains a significant exposure to my blood or body fluids, I may be asked to undergo testing for HIV, (the virus that causes AIDS), and hepatitis. The results of any test will be confidential and will be treated in accordance with California law. I understand that, in accordance with California law, a positive HIV test result will be reported to the county health department with sufficient information to identify me. Furthermore, I hereby authorize the Endoscopy Center of Inland Empire and my physician to disclose such HIV test results to any third-party payor, as appropriate for processing and payment.

(F) If a Physician Has Signed and Issued DNR (Do Not Resuscitate) Order for You: If I have consented to a do not resuscitate order ("DNR"), I understand and acknowledge that my consent to a DNR order is temporarily SUSPENDED while I undergo any procedure performed at this Facility. It is the policy of this center that, regardless of the contents of any advance directives/living will or instruction from a health care surrogate, patient representative, or attorney, the Center will always attempt to resuscitate and transfer you to an acute health care facility in the event of deterioration.

(G) Use/Disposal of Tissue: I hereby authorize the Facility to retain, photograph, preserve, dispose and submit for scientific or teaching purposes, or dispose of at its convenience any specimens or tissues taken from my body during my procedure or treatment. Specimens or tissues removed may be sent to a laboratory for further testing or examination by a pathologist.

(H) Consent for Transfer: I understand that the surgical and/or diagnostic procedure to be performed on me at the facility will be done on an outpatient basis and that the facility does not provide 24-hour patient care. If my attending physician or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the facility to a hospital, then, I consent and authorize the employees of the facility to arrange the transfer. In an event of a hospital transfer, I consent to the surgery center obtaining a copy of my discharge summary from the hospital.

(I) Observation Consent: For medical, scientific or educational purposes, I consent to the admittance of approved observers to the procedure room and release of Endoscopy Center of Inland Empire and the attending physician from any liability that may arise from their presence in the procedure room.

(J) Photographs: I consent to the taking and publication of any-photographs in the course of this operation for the purpose of treatment and/or medical education.

(K) Certification and Signatures: I certify that I understand the information regarding my procedure and the administration of anesthesia (if necessary) and that I have been fully informed of the risks and possible complications thereof, as well as, medically acceptable alternatives to my procedure. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. I hereby authorize and permit the physician and whomever he/she may designate as his/her assistants to perform upon me the named procedure(s).

If any unforeseen condition arises during the procedure calling in his/her judgment for additional procedures or medications, I further request and authorize him/her to do whatever he/she deems advisable.

I certify that I have been informed that I may receive a sedative for this procedure. I understand that I should not drive, operate machinery, make critical decisions, or drink any alcohol until the day after my procedure. I have signed this form prior to receiving sedation.

Have you ever had a Hysterectomy or sterilization procedure? YES, NO, N/A

I understand that certain procedures and/or drugs may be harmful to me and my unborn child. YES, NO, N/A

I voluntarily assume the risk of any injury or damage to me and my unborn child if I am pregnant. YES, NO, N/A

I refuse the facility urine pregnancy test. YES, NO, N/A

MEDICATION RECONCILIATION RECORD

Please complete the following medication record including dose, frequency and reason for taking. Although you may have informed the physician's office of the medication you are taking this form needs to be completed and brought with you to the Endoscopy Center. The nurse will review this with you upon admission to ensure there are no meds that may interfere with your procedure or sedation to ensure the safest patient care and outcome.

Medication List provided by patient

(Include: prescription and OTC, herbals, vitamins, nutritional supplements, and alternative therapy, etc)

Medication/Vitamin/Supplement Name	Dose Mg/Mcg *Quantity*	Frequency *Ex Twice a day*	Reason for taking	Last dose taken

Allergies, including reaction type: