Gastrointestinal Specialists, Inc. GI-ASC LLC
Consent to Diagnostic/Therapeutic Procedure

I authorize Doctor: Lefton/Pilchman/Schapiro/Cheung/Lehrer/Rosa/Cohen/Kalakuntla to perform upon myself the following operation or diagnostic/therapeutic procedure:

[ ] **Colonoscopy** -Insertion of a flexible scope instrument thru the rectum into the large intestine. The performance of biopsies, polyp removal, and tissue coagulation/cautery may need to be performed.

[ ] **Endoscopy (EGD)** – Insertion of a flexible scope instrument through the mouth into the esophagus, stomach and duodenum (intestine). The performance of biopsies, polyp removal, and esophageal dilatation may be necessary to dilate esophagus and tissue coagulation/cautery may need to be performed.

[ ] **Flexible Sigmoidoscopy**: Insertion of a flexible scope instrument through the rectum into the sigmoid colon. The performance of biopsies, polyp removal, and tissue coagulation/cautery may need to be performed.

I am aware that no guarantees have be made to me concerning the results of the of the operation or diagnostic/therapeutic procedure.

If, during the course of the diagnostic/therapeutic procedure, unforeseen conditions may be revealed that necessitate change or extension of the original procedure(s) or different procedure(s) than those already explained above, I authorize and request that the above named physician, his assistants, or his designees perform such procedure(s) as are necessary and desirable in the reasonable exercise of his/her professional judgment.

I have been made aware that there are risks, discomforts, and possible undesirable consequences associated with the treatment and diagnosis of my condition, including (but not limited to) severe blood loss, infection, organ puncture/perforation, heart and lung complications, blood blots or death (complications may require hospitalization and/or surgery). I have discussed the risks vs. benefits associated with performing the procedure in the Ambulatory Surgical Center instead of the hospital. Advanced Directives will be suspended in the Ambulatory Surgery Center.

I understand that in addition to the risks explained to me, the possibility of other risks and consequences may arise. I understand that no procedure is guaranteed 100 percent, there is a small risk of missed polyps, cancer or other lesions.

I authorize the anesthesia personnel to administer certain anesthetics attendant to the procedure that I am about to undergo. The consent will apply to the administration of such anesthetics as may be considered necessary or advisable.
The risks, benefits and purpose of the administration of the anesthesia have been or will be explained to me as well as the possible alternatives which are available. I will be given the opportunity to ask my anesthesiologist further questions regarding the administration of anesthesia as it applies to my procedure.

I understand that the participating physicians may have a financial interest in the facility where the procedure(S) will be informed, and I have been offered an alternative site for the procedure(s).

In the event of an emergency transfer to the hospital is necessary, patients presenting with advanced directives will be informed their advance directive will follow then to the hospital. In which case the advanced directive will go in effect upon admission to hospital. Understanding all of the above, I intend to be legally bound by this informed consent, which I'm signing voluntary after it has been completed and after I have had the opportunity to read and fully understand it. I hereby authorize the performance of the above noted procedures). I hereby certify I have discussed and explained the procedure(s) an answered any question referring to the procedure(s) in this consent, with the individual granting consent.

_____ _____
Physician Signature Date & Time

_____ _____
Patient's Signature Date & Time

Witness to signature:_____ Date & Time_____

If consenting party is other than patient:_____
Signature Date & Time of Consenting Party

Relationship to patient:_____ If patient unable to sign, please state

reason:_____

GI-ASC AMBULATORY SURGICAL CENTER
MEDICAL OFFICE BUILDING
10800 KNIGHTS RD STE 242
PHILADELPHIA, PA 19114
215 632 3500

Appointment Date: _____

*IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED PROCEDURE APPOINTMENT, PLEASE NOTE THAT OUR OFFICE REQUIRES A MINIMUM OF 48 HOURS' NOTICE TO AVOID A CANCELLATION FEE OF $ 200.00.***

YOU WILL RECEIVE A CALL THE DAY BEFORE YOUR PROCEDURE WITH YOUR TIME*

***IF YOU DO NOT RECEIVE A CALL BY 2PM THE DAY BEFORE YOUR PROCEDURE, PLEASE CALL THE OFFICE AT 215 632 3500 ***

PLEASE BRING INSURANCE CARD & PHOTO I.D. DAY OF PROCEDURE

COLONOSCOPY PREPARATION INSTRUCTIONS

You have been scheduled for a colonoscopy with Gastrointestinal Specialists, Inc. This is an examination of your large intestine (colon). Your colon will be examined in detail. Additional procedures may be performed such as taking tissue samples (biopsies) and removing polyps.

- Please read all the prep instructions at least **ONE WEEK** before your scheduled procedure date so you can be adequately prepared for this procedure.
- You will be notified within a week of your scheduled procedure with your benefit information such as any co pays/coinsurance and/or referral responsibilities.
- DO NOT WEAR ANY JEWELRY TO YOUR PROCEDURE. WE ARE NOT RESPONSIBLE FOR THE LOSS OF ANY VALUABLES: EARRINGS, RINGS AND/OR WATCHES.

We strive to remain on schedule, please understand that performing a procedure such as colonoscopy may take longer in some patients than in others. As a result, your procedure may not be performed at the exact time you were scheduled. Please be patient and allow additional time for your procedure

To ensure you are comfortable and relaxed during the procedure, intravenous sedation medication will be given.

IMPORTANT INFORMATION YOU NEED TO KNOW:

1) YOU MUST HAVE A RESPONSIBLE ADULT (18+ YRS) WITH A VALID DRIVER'S LICENSE COME TO OUR OFFICE AND SIGN YOU OUT AND ESCORT YOU HOME
2) YOU MAY NOT DRIVE HOME AFTER YOU RECEIVE SEDATION.
3) YOU MAY NOT DRIVE UNTIL THE DAY AFTER YOUR PROCEDURE.
4) YOU MAY NOT GO HOME ALONE IN A TAXI, SHUTTLE VAN OR BUS, AS THE DRIVERS WILL NOT SIGN YOU OUT OF OUR FACILITY & BE RESPONSIBLE FOR YOUR CARE AFTER YOUR PROCEDURE. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY CAUSE CANCELLATION AND/OR RESCHEDULING OF YOUR PROCEDURE.**
5) NO SMOKING (CIGARETTES, PIPE, CIGAR, E-CIGARETTE OR MARIJUANA) ON THE DAY OF YOUR PROCEDURE

SPECIAL MEDICATION INSTRUCTIONS

PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS, WITH DOSES THE DAY OF YOUR PROCEDURE.

You may take cardiac, blood pressure, anxiety and respiratory medications (inhalers may be used) on the morning of your procedure with a small sip of water.

The following medications may need to be stopped 5-7 days prior to your scheduled procedure. Please discuss this with your prescribing physician and cardiologist:

- Arthritis medications (Motrin, Ibuprofen, Naprosyn, Celebrex, etc.).
- Blood thinners (Coumadin, Aspirin, Plavix, Aggrenox, etc.)

Diabetic Patients:
Please check with your primary care physician or endocrinologist for special instructions for insulin or other diabetic medications.

A LIST OF ACCEPTABLE CLEAR LIQUIDS

IMPORTANT-YOU MUST BE ON A CLEAR LIQUID DIET THE ENTIRE DAY PRIOR TO YOUR PROCEDURE – NO SOLID FOOD - REGARDLESS OF TIME*

NO RED OR PURPLE NO FRUIT PIECES OR TOPPINGS **NO ALCOHOL ALLOWED**

- Gatorade – blue, orange, yellow & green are acceptable
- Hot tea/iced tea/coffee – sugar, splenda & honey acceptable -no milk or creamer allowed
- Carbonated drinks such as 7-up, sprite, ginger ale & orange
- Jello – blue, orange, yellow & green acceptable
- Clear chicken broth, beef broth or vegetable broth
- Popsicles – blue, orange, yellow & green acceptable
- Water ice – blue, orange, yellow & green acceptable
- Fruit juices such as apple juice, white grape juice and white cranberry juice

PORTANT-YOU MUST BE ON A CLEAR LIQUID DIET THE ENTIRE DAY PRIOR TO YOUR PROCEDURE – NO SOLID FOOD - REGARDLESS OF TIME*

NOTHING BY MOUTH FOR 4 HOURS PRIOR TO YOUR PROCEDURE TIME

[ ] SUPREP: **First dose** begins at _____ **PM** 1) Pour (1) 6 oz bottle of Suprep liquid into the mixing container. 2) Add cool drinking water **OR** a clear liquid of your choice to the 16oz line on the container & mix. 3) Drink **all** the liquid in the container. 4) You must drink (2) more 16oz containers of water over the next hour. **Second dose** begins at _____ **AM/PM** for this dose, repeat steps 1 through 4 shown above using the other 6 oz bottle.

[ ] MOVIPREP: Empty one pouch A & one pouch B into disposable container. Add lukewarm drinking water **OR** a clear liquid of your choice to the top of line on bottle. Cap the bottle & shake to dissolve the powder. Refrigerate. Start to drink solution at _____ **PM** at least 8ozs every 15 minutes (approx 4 glasses) until the bottle is completed. **Second dose** begins at _____ **AM/PM** for this dose, repeat the entire process. Drink at least 32 ounces of clear liquids during the course of the evening.

[ ] CLENPIQ: At _____ **PM** the night before your colonoscopy: Drink 1 bottle of Clenpiq directly from the bottle, then drink 5 cups (8oz each) of clear liquids. Continue clear liquid diet until midnight. Five (5) hours prior to your colonoscopy time: Drink the other bottle of Clenpiq directly from the bottle, then drink 3 cups (8oz each) of clear liquids. **No more liquids until after your procedure (unless otherwise instructed for medication purposes)**

[ ] PLENVU: At _____ **PM** Use the mixing container to mix contents of the Dose 1 pouch with at least 16 ounces of water then shake or mix with spoon until it's completely dissolved. This may take up to 2 to 3 minutes. Take your time - slowly finish the dose within 30 minutes. Refill the container with at least 16 ounces of clear liquid. Again, take your time and slowly finish all of it within 30 minutes.

Second dose begins at: _____**AM** Use the mixing container to mix contents of Dose 2 (Pouch A and Pouch B) with at least 16 ounces of water then shake or mix with spoon until it's completely dissolved. This may take up to 2 to 3 minutes. Take your time – slowly finish dose within 30 minutes. Refill the container with at least 16 ounces of clear liquid. Again, take your time and slowly finish all of it within 30 minutes.

[ ] MIRALAX: 1) At **5:00pm** the night before your colonoscopy take (2) Dulcolax tablets (laxative) 2) At 7pm Mix 238 grams (7oz bottle) of Miralax in 64ozs of Gatorade. **Drink 32ozs of the Miralax mixture** (approximately (1) 8oz glass every 30 minutes until 32ozs is complete) Refrigerate remaining 32ozs. Repeat 5 hours prior to your procedure time the **remaining 32ozs of the Miralax mixture.**

[ ] GOLYTELY:
This prep comes in powder form. Mix it with (1) gallon of water. Refrigerate the solution early in the morning so that it can chill throughout the day. Start to take prep **4:00pm**. Drink (1) 8oz glass every (20) minutes until entire solution is complete.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

Should your physician determine you require diagnostic or preventive endoscopy or colonoscopy, your procedure will be performed at GI-ASC,LLC. The ambulatory surgery center is licensed by the Commonwealth of Pennsylvania, Accreditation Association for Ambulatory Health Care (AAAHC) and approved by Medicare.

The ambulatory surgical center is an outpatient facility, therefore your insurance carrier will be billed a facility fee and any outpatient copay, co-insurance and or deductible will apply based on your insurance policy. You will be responsible for any copays and co-insurances which are due at the time of service. Also, if your policy has a deductible, you may receive a bill for additional payment after the claim has been processed by your insurance company. If you are uncertain of your policy deductibles, please contact your insurance company for this information. Please be aware you may also receive bills from anesthesia, pathology and physician.

If you have questions please contact the billing department

Gastrointestinal Specialists Inc. Billing Department 215-702-0506

Anesthesia (Origin Healthcare Solutions) 201-804-5248