Digestive Health Associates of Northern Michigan, P.C.
4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone: (231) 935-5710 x4 Fax: (231) 935-9045 Web: https://www.dha-nm.com

APPOINTMENT DETAILS

DATE:	Your Colonoscopy is scheduled for _____. You can expect to be at the facility for 2.5 – 3 hours.
ARRIVAL AT COPPER RIDGE SURGERY CENTER:	You will be contacted two days before your procedure (after 4pm) with your arrival time. You will receive this reminder in the form of an email, text message, and automated phone call- in that order, until confirmed. If you do not receive your arrival time, please call the office (231-935-5710 x4) the day before your scheduled appointment time to verify this information. Present to the desk on the main floor of the Copper Ridge Surgery Center.
ARRIVAL AT MUNSON MEDICAL CENTER:	Please arrive one hour prior to your scheduled surgery time. Please report to the Munson Medical Center's Registration Desk.
PRESCRIPTION:	Your prescription has been electronically sent to your pharmacy.
PLEASE BRING:	On the day of your procedure: ✓ A driver over the age of 18 who will remain in the building during your procedure ✓ Completed Medication and Allergy List ✓ Insurance Cards ✓ Photo ID
PRE-REGISTRATION:	If you have provided us with an email address, you will be sent a pre-registration email before your visit. If you do not complete the pre-registration email online, please complete the paperwork provided in this packet and bring it with you. There will be a separate registration process when you check in with the facility.
COLONOSCOPY:	This procedure is a direct examination of the colon through a flexible lighted scope, which is inserted through the rectum. For the examination, you will lie on your left side for the passage of the scope. An intravenous catheter will be placed in one of your arms to administer sedative medications. After the examination there is generally a temporary feeling of fullness in the colon, and air can be expelled through the rectum. **You should not drive, operate power machinery, or make major decisions the day of the colonoscopy, as the medications may affect your judgment.**

Digestive Health Associates of Northern Michigan, P.C.
4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone: (231) 935-5710 x4 Fax: (231) 935-9045 Web: https://www.dha-nm.com

GALLON/BISACODYL COLONOSCOPY PREP INSTRUCTIONS

Please read through the attached instruction packet to see how you prepare for your colonoscopy. Your prescription has been sent to your pharmacy. Please pick it up as soon as possible.

THE DAY BEFORE YOUR COLONOSCOPY

1. BEGIN CLEAR LIQUID DIET:

   - ARRIVAL TIME BEFORE 1:00PM: Clear liquid diet starts the entire day prior to your exam and continues up until 4 hours before your test.

   - ARRIVAL TIME AFTER 1:00PM: You may have a light breakfast before 8:00am (the day before the procedure), then begin a clear liquid diet. You will continue clear liquids up until 4 hours before your test.

   CLEAR LIQUID DIET

   - No **RED or PURPLE** liquids should be consumed. You can have any of the following foods up **until 4 hours before** your colonoscopy.
   - It is very important to stay hydrated. Make sure you drink plenty of clear liquids.

   ✓ Water or Flavored Water
   ✓ Tea (No Red or Purple Colors)
   ✓ Carbonated Beverages such as Sprite, 7up, Gingerale (Avoid Red, Purple, or Dark Sodas)
   ✓ Fruit Flavored Drinks (No Red or Purple)
   ✓ Weak Coffee (No creamer)
   ✓ Strained Fruit Juices (No Red or Purple)
   ✓ Apple Juice
   ✓ White Grape Juice
   ✓ White Cranberry Juice
   ✓ Powdered Lemonade
   ✓ Popsicles (No Red or Purple)
   ✓ Jello (No Red or Purple)
   ✓ Gatorades (No Red, Purple, or Blue Colors)
   ✓ Ensure "Clear"- must be see through
   ✓ Clear Hard Candy (No Red or Purple)
   ✓ Honey
   ✓ Syrup
   ✓ Sugar
   ✓ Clear Broth(Chicken, Vegetable, or Beef)
   ✓ Bouillon Cubes
   ✓ Protein shakes that are "Clear"- must be see through

2. PREPARE THE GALLON PREP SOLUTION
   - Add lukewarm drinking water to the top of the line on the bottle.
   - Mix to dissolve the powder.
   - If you prescription does not you can purchase flavor packets (like Crystal Light) and add to solution.
   - You can refrigerate the solution or keep it at room temperature.

3. AT 12:00 P.M. (NOON)
    - Take one Bisacodyl tablet with a glass of water. Do NOT chew or crush the tablet. Make sure to drink plenty of fluids.
4. AT 6:00 P.M.
    - Drink 1 (8oz) glass of the NULYTELY solution every 10 minutes (4 glasses).
    - Rapid drinking is preferred and you may drink with a straw.
    - The solution will cause bowel movements so remain close to a bathroom.
    - Mild nausea and abdominal fullness are expected with this preparation. If you experience severe nausea or vomiting, stop the preparation for 30 minutes to one hour, and then restart at the same rate as before. The bowel movements should eventually become clearer
    - If your bottom gets sore from too much wiping, try putting Vaseline on the tender areas.

THE DAY OF YOUR COLONOSCOPY

1. FIVE HOURS PRIOR TO LEAVING YOUR HOME FOR YOUR PROCEDURE
    - Drink 1 (8 oz) glass every 10 minutes (about 4 glasses).
    - Discard the remainder of the solution.
    - You can continue to drink clear liquids up to 4 hours before the colonoscopy. Then, do not eat or drink anything until after your procedure.
    - The solution will cause bowel movements so remain close to a bathroom.

Medications

- You may take your pills with sips of water up to three hours before your test. If you take blood pressure medications be sure to take them before your procedure.

Blood Thinners

- If you take Coumadin (warfarin), Xarelto (rivaroxaban), Eliquis (apixaban), Pradaxa (dabigatran), Lovenox (enoxaprarin), Plavix (clopidogrel), Effient (prsugrel, Brilinta (ticagrelor), Aggrenox (aspirin-dipyrdomole), Savaysa (edoxaban), or Heparin, please follow the instructions given to you by DHA's Medical Assistants.

If you have diabetes

- Do not take any diabetes pills the day of your procedure.
- If you are on Insulin please contact your primary doctor for instructions.
- If you use an Insulin pump please contact your primary care doctor for instructions.

If you have any questions or concerns regarding the preparation, please call and discuss them with our nurse. If you experience pain or vomiting, please call the office immediately. Call the Digestive Health Associates Gastroenterologist on call at 231-360-2884 if you experience these difficulties after hours.

Digestive Health Associates of Northern Michigan, P.C.

SCREENING COLONOSCOPY vs. DIAGNOSTIC COLONOSCOPY

If you were sent to one of our physicians for a **"Screening Colonoscopy"** or you have seen the provider and he/she recommends a colonoscopy, please read this form in its entirety. You need to be fully educated on the state and federal guidelines for reimbursement services.

The Centers for Medicare & Medicaid Services (CMS) **"Screening Initiatives"** passed in January, 2011 dictates that patients undergoing a **"screening colonoscopy"** will not be held to their coinsurance or deductible responsibilities.

The definition of a **"screening colonoscopy"** per CMS guidelines is as follows:

> *"A colonoscopy being performed on a patient who does not have any signs or symptoms in the lower GI anatomy PRIOR to the scheduled test."*

Any symptom such as change in bowel habits, diarrhea, constipation, bleeding, anemia, etc. prior to the procedure and noted as a symptom in your medical record may change your benefit from a screening to a diagnostic colonoscopy. We cannot change your medical record after you have been seen. We cannot change the fact that you have had symptoms prior to your procedure.

Please note: If you have had a colonoscopy within the last 10 years and the result indicated you had colon polyps, you may **NOT** be eligible for "screening initiative" benefits. You have a prior history of polyps. Your colonoscopy is now considered a "surveillance of the colon" and may be considered diagnostic. You may have been healthy and have had no symptoms since your last colonoscopy, but you have what is considered a pre-existing nature of polyps and therefore, are not eligible for a "screening". If your colonoscopy has been over 10 years, you are eligible for a "screening colonoscopy" regardless of your history. ***It is your responsibility to know your insurance benefit. Please contact your insurance company with benefit questions prior to your procedure.***

Please be advised that if you are a true "screening colonoscopy" and during the procedure your doctor finds a polyp or tissue that has to be removed for pathological testing or if you are diagnosed with a GI problem, the procedure is no longer a "screening" but becomes "diagnostic". Please be aware that any polyp that is found may be pre-cancerous and must be removed. Your insurance benefits may change. We make every effort to code correctly for your procedure with the correct modifiers and diagnoses. We make every effort to work with the facility to have the billing coded correctly, as well. The correct coding of a procedure is driven by the physician and your medical history. It is not dictated by your benefit or the insurance company.

**These guidelines are CMS requirements and DHA providers are unable to make exceptions.*

Digestive Health Associates of Northern Michigan, P.C.
4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone: (231) 935-5710 Fax: (231) 935-9045 Web: https://www.dha-nm.com

NOTICE OF PRIVACY POLICIES

I understand Digestive Health Associates of Northern Michigan, P.C.'s notice of privacy practices are available upon request and are also posted on the bulletin board in the waiting room of their office.

NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide adequate notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancelations made less than 24-48 hours notice, we are unable to offer that appointment slot to other people.

- Patients who fail to show for their scheduled office appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show" penalty of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given - and an exception may be granted.
- Patients who fail to show for their scheduled procedure appointment or do not notify the office within 48 hours of their scheduled appointment time shall be subject to a "No Show" penalty of $150.

We understand that special unavoidable circumstances may cause you to cancel within this time frame. Fees in this instance may be waived but only with management approval.

OWNERSHIP

Copper Ridge Surgery Center, LLC is a joint venture between a group of Traverse City physicians and Munson Medical Center to improve patient access to outpatient procedures in our community. The group of physicians owns the land and building which is leased to the joint venture – Copper Ridge Surgery Center.

For the purpose of complete financial disclosure, we would like to inform you that Dr.'s **Rex Antinozzi, Robert Barnes, Mark Galan, Jeffrey Goldman, Monty Hegewald, and Glen Henbest** have ownership interests in the surgery center. As such, the fee for use of the facility will go to the joint venture.

All physicians on staff at Copper Ridge Surgery Center are also on staff at other facilities in the area. You have the right to request that the procedure be performed at another facility. If you have questions regarding this issue, feel free to discuss it with your physicians.

By signing below, I acknowledge that I have read and understand to all of the above and wish to proceed with my scheduled surgery at Copper Ridge Surgery Center.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

Digestive Health Associates of Northern Michigan, P.C.
4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone: (231) 935-5710 Fax: (231) 935-9045 Web: https://www.dha-nm.com

PATIENT INFORMATION FORM

DATE / /

LAST	FIRST	MIDDLE	NICKNAME
PERMANENT ADDRESS	CITY	STATE	ZIP
SECONDARY/MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	E-MAIL ADDRESS

SOCIAL SECURITY # — —	BIRTHDATE / /	GENDER ☐M ☐F	MARITAL STAUS S – M – W – D	EMPLOYER

ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO	RACE ☐ AFRICAN AMERICAN ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐CAUCASIAN ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐MULTIRACIAL ☐ OTHER	PREFERRED LANGUAGE ☐ ENGLISH ☐ OTHER _____

SPOUSE	SPOUSE SOCIAL SECURITY # — —	SPOUSE BIRTHDATE / /	SPOUSE EMPLOYER
GUARDIAN	GUARDIAN RELATIONSHIP	GUARDIAN BIRTHDATE / /	GUARDIAN PHONE

EMERGENCY CONTACT	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE #

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Digestive Health Associates of Northern Michigan, P.C. (Drs. Antinozzi, Barnes, Carroll, Galan, Goldman, Hegewald, Henbest, Weick, Kathy Holmstrom-Baker, PA-C, Sarah Flickinger, PA-C, Rachael Farrell, PA-C) to release and/or discuss information relevant to my care to the following individuals:

_____Spouse (Name) _____

_____Other (Name and Relationship) _____

I also authorize information about my health care, including appointments, test results or other messages, to be left on my answering machine, in the event that I am not available.

_____ Yes _____No

I request payment of authorized Medicare or other insurance benefits to be made to either myself or on my behalf to Digestive Health Associates of Northern Michigan for any services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administrating benefits.

_____Medicare
_____Other Insurance (Name of Company) _____

I understand that I am financially responsible for any amount not covered by my insurance contract. I accept responsibility for obtaining necessary referral forms.

This release will be considered valid from the date indicated below and will remain in effect until such time as I withdraw it in writing.

_____ _____ _____
Signature of Patient Date Witness

Copper Ridge SURGERY CENTER

COVID – 19 Patient Instructions

To protect patients and staff and to comply with current CDC guidelines, Copper Ridge Surgery Center (CRSC) is screening our patients and visitors for COVID - 19 symptoms upon entry to the facility.

Upon arrival, you will be requested to wear a fresh mask, provided to you by us. You will be asked to sanitize your hands and asked a series of questions about COVID – 19.

- Do you have a dry cough that is new?
- Do you have a sore throat?
- Are you experiencing shortness of breath?
- Have you had a fever?
- Do you have flu-like symptoms?
- Have you tested POSITIVE for COVID in the past?
- Have you been in close contact with someone who has tested positive in the last 10 days?

It is very important that, if you develop any of the above symptoms prior to your procedure, do NOT come to your appointment until you have contacted your physician for directions.

VISITORS:

We request that you only bring one (1) visitor with you who is healthy and not exhibiting the above symptoms. Your visitor/family member/driver will be asked to wait out in the vehicle for you. Although our lobby is arranged to assist with social distancing, we are asking that only patients wait there. Please provide our registration staff with a phone number for the driver and we will contact them with further instructions. Our restrooms are open and available for use as long as you have been through the COVID – 19 screening process.

Name: _____

Birthdate: _____

Effective Date: 4/24/2015

Copper Ridge SURGERY CENTER

Medication and Allergy List

PLEASE COMPLETE AND BRING THIS WITH YOU ON THE DATE OF YOUR PROCEDURE

Have you been allergy tested? ☐ **Yes** ☐ **No** **Are you allergic to:** ☐ **Latex** ☐ **Iodine** ☐ **Eggs**

☐ **Metals (including jewelry)? If yes, what type:** _____

Medication Allergy	What happens?

Please list your current medications below, including vitamins, herbal medications and meds prescribed but not taken.

TAKING BLOOD THINNERS (ex: Aspirin, Plavix, Coumadin, and Pradaxa)? ☐ **Yes** ☐ **No**

If yes, time of last dose: _____

Medication Name	Dose (eg: 2 mg)	How often?	When Last Dose Taken?

(If space needed for additional medications, please list on reverse)

Medications reviewed at admission: _____ **Date/Time:** _____

Nurse Signature