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 EGD 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.
PLEASE BRING:	On the day of your procedure: ✓ A driver over the age of 18 with a valid driver's license ✓ Completed Medication and Allergy List ✓ Insurance Cards ✓ Photo ID
PRE-REGISTRATION:	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.
EGD:	This procedure is a visual examination of the lining of the esophagus, stomach, and duodenum; performed with a small flexible lighted scope. Intravenous sedation will be continued to keep your comfortable. **You should not drive or operate power machinery the day of your procedures, 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 Fax: (231) 935-9045 Web: https://www.dha-nm.com

EGD (Esophagogastroduodenoscopy) PREP INSTRUCTIONS

Consume no solid food from midnight the night before your appointment; however it is acceptable to consume CLEAR NON-RED LIQUIDS ONLY (see below) up until 4 hours before your appointment.

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

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.

Diabetics

- Do not take your insulin if your test is before noon. Bring it with you.
- If you test is after noon, take one-half of your usual dose of long-acting insulin (NPH, Lente, Semi Lente). If you take 70/30 insulin take 1/3 of your normal dose.
- Do not take any regular or short-acting insulin.
- If you take pills for your diabetes, do not take them on the day of your test. Bring them with you.
- We would rather your sugar was running a little high than low.
- 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.
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. Carroll, Galan, Goldman, Hegewald, Henbest, Kathy Holmstrom-Baker, PA-C, Sarah Flickinger, PA-C, Rachael Carter, PA-C, Ana Zubaryeva, PA-C, Anne-Marie Deming, 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

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 2 business days before 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 **Heather Carroll, 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

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