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
www.dha-nm.com

Your EGD is scheduled for:_____

Your procedure is scheduled at the Copper Ridge Surgery Center. You will receive an automated telephone call two days prior to your appointment with procedure time and arrival information. If you do not receive this call, please call our office the day prior to your scheduled procedure to verify this information.

Your procedure is scheduled at Munson Medical Center. Please report to the Munson Registration desk by:_____

EGD (esophagogastroduodenoscopy) is a visual examination of the lining of the esophagus, stomach, and duodenum; performed with a small flexible lighted scope.
After checking in with registration, you will be taken to the medical procedure room. There, a nurse will explain this procedure to you. Please inform the nurse if you have any known medication allergies. You will be asked to sign a consent form.
The nurse will then spray your mouth with a local numbing medication which will provide anesthesia to the back of your throat. Medication is given during the test for comfort and relaxation. The examination takes approximately 20 minutes.
After completion of the EGD, you will be asked to remain in the outpatient procedure room until most of the effects of the medication wear off, generally 30 – 60 minutes. Discharge instructions will be given to you by the nursing staff.
We require that you bring a family member or close friend with you as a driver. The medications given may affect you judgment, and you may be sleepy for the remainder of the day. You should not drive, ride a bicycle, or operate power machinery the remainder of the day following the procedure.

PREPARATION FOR EGD: To prepare yourself for the EGD, consume no solid food from midnight the night before your appointment; however it is acceptable to consume **CLEAR NON-RED LIQUIDS ONLY** up until four hours before your appointment.

CLEAR LIQUID DIET

This diet includes low residue fluids that are easily absorbed with minimal digestive activity. This diet does not contain all essential nutrients and is recommended if clear liquids are temporarily needed. **No RED or PURPLE liquids** should be consumed. You can have any of these foods at any time up **until 4 hours** before your test.

***4 hours before your test, you will need to refrain from everything including water

This a list of food/liquids allowed. Please **choose only** items from this list.

water
flavored water
decaffeinated tea
carbonated beverages, such as Sprite, 7up, ginger ale (**avoid red, purple or dark sodas**)
fruit flavored drinks (**no red or purple colors**)
weak coffee
strained fruit juices (**no red or purple colors**)
apple juice
white grape juice
powdered lemonade
white cranberry juice
clear broth (chicken or beef)
bouillon cubes
Jello (**no red or purple colors**)
popsicles (**no red or purple colors**)
sugar
honey
syrup
clear hard candy (**no red or purple colors**)

Digestive Health Associates of Northern Michigan, P.C.

Medications:

- You may take your pills with sips of water up to three hours before your test.

Coumadin and other Blood Thinners:

- If you take Coumadin (Warfarin), Ticlid, Plavix, Heparin, Aggrenox, Lovenox, Effient, or Persantine please ask the doctor who prescribed this medication for you when you should stop taking it.
- If you take Coumadin (Warfarin), or Plavix, you must see us in the office or speak with someone from our office at least seven days prior to your procedure.

Diabetics:

- Do not take your insulin if your test is before noon. Bring it with you.
- If your 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 have any questions or concerns regarding the preparation, please call and discuss them with our nurse. Office hours are Monday-Friday, 8:00a.m. to 5:00p.m. If you experience extreme pain or vomiting, please call the office immediately. Contact the Gastroenterologist at if you experience these difficulties after hours.

Copper Ridge SURGERY CENTER

Medication and Allergy List

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

Name: _____ Birthdate: _____

Indicate if you allergic to:

☐ Latex ☐ Iodine ☐ Eggs ☐ Metals (including jewelry), what type: _____

Have you been allergy tested? ☐ Yes ☐ No

Medication Allergy	What happens?

Please include vitamins and herbal medications as well as meds prescribed but not taken.

Medication Name	Dosage	Frequency (how often taken)	Date of Last Dose

[ ] BLOOD THINNERS (examples: Aspirin, Coumadin, Plavix, Pradaxa):

Last dose: _____

Confirmed with patient _____ DOS: _____

Nurse Signature

Digestive Health Associates of Northern Michigan, P.C.

Acknowledgement of Receipt
Notice of Privacy Practices

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.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth

NOTICE

Your procedure is scheduled to take place at Copper Ridge Surgery Center, LLC on (insert date)_____.

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 this disclosure 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.

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 EMPLOYER
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, Galan, Goldman, Hegewald, Henbest, Sanford, Rachael Farrell, PA-C, Sarah Flickinger, PA-C, Kathy Holmstrom-Baker, PA-C, and Allie Nave, 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

COMMUNITY REGISTRY DISCLOSURE AND AUTHORIZATION

Patient Information	
Name: _____	Phone Number: _____
Address: _____	E-mail Address: _____
_____	Date of Birth: _____

Digestive Health Associates of Northern Michigan, P.C. participates in a Community Registry operated by Northern Physicians Organization, Inc. (NPO). This Registry is a tool that we and others involved in your care can use to carry out your treatment and engage in activities to help manage your care such as coordinating your care, conducting quality assessment and improvement activities, and related planning and management activities that do not include treatment (*i.e.*, health care operations).

__ I opt-out of the NPO Community Registry.

- OR -

__ I understand that by signing this form, I agree to allow the providers involved in my health care to talk to each other about my care, electronically share my health information with each other to give me better care, and to use my information in health care operations. The software system used by NPO meets the privacy and security standards of both the Health Insurance Portability and Accountability Act (HIPAA) and Michigan law.

WHAT MAY BE DISCLOSED: I authorize my Provider to disclose all of my health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion, alcohol or drug use problems, my care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this Authorization.

WHO MAY RECEIVE THE INFORMATION:

(1) I authorize my Provider to disclose my health information to NPO and its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and

(2) I authorize NPO to disclose my health information to **(a)** its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and **(b)** other health care service providers (*e.g.*, labs and hospitals) that have entered into a written agreement with NPO, where they have agreed to comply with HIPAA and Michigan privacy laws.

PURPOSES: I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, and to improve my provider's health care operations.

EXPIRATION: This consent will expire, **(i)** upon my death, **(ii)** when my Provider ceases its relationship with NPO, or **(iii)** NPO ceases operation of the Community Registry, whichever is sooner.

REVOCATION: I can revoke my permission at any time by giving written notice to my provider except to the extent the disclosures I agreed to have already been acted on.

ADDITIONAL RIGHTS: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these rights are further explained in my Provider's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent/Guardian or Personal Representative Date Authority to Act

Digestive Health Associates of Northern Michigan, P.C.

"No Show" Policy
For Office Visits & Procedures

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.

Please sign that you have read, understand, and agree to this "No Show" Policy.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth