You have been scheduled for a colonoscopy in our facility. Enclosed is information about how to prepare for your procedure. Please read these instructions as soon as possible as some medications must be stopped a week before your colonoscopy.

We strive to stay on schedule. Our goal is to begin your procedure 30 minutes to one hour after your assigned arrival time as noted above. Approximately 30 minutes is needed to get you ready for your procedure. Your expected time at the endoscopy center will be 3 hours or less. To minimize delays, if you arrive late or without completed paperwork, we may move you to the end of the schedule.

Please bring the following to your appointment:
1. Your current medications (or updated list of medications and dosages)
2. A responsible adult who must stay during your procedure and drive you home
   a. You must not operate a motor vehicle until the following day
   b. Your driver must stay in the waiting room during your procedure
   c. This person will help you remember what the doctor tells you about the results. Your short-term memory will not be working for a while after the procedure.
3. Two forms of ID or one photo ID (i.e. driver’s license, passport, school ID card)
4. Your Insurance Card
5. The attached completed forms
   a. Heritage Medical Associates’ Financial Policy
   b. Patient Registration Form
   c. Gastroenterology Evaluation Form

We are honored by the trust you are placing in us and appreciate the opportunity to serve you.

Sincerely,

Digestive Disease Endoscopy Center Staff

Wireless internet is available in our waiting room.
PREPARING FOR YOUR COLONOSCOPY

If you have questions, please call:
Dr. McMillen 629-255-2155
Dr. Parker 629-255-2156
Dr. Roberts 629-255-2157
Dr. Shull 629-255-2158
Dr. Wright 629-255-2159

A. So that we may take appropriate precautions, please notify us as soon as possible if:
   • You are taking blood thinners
     (COUMADIN, PERSANTINE, PLAVIX, ELMIRON, EFFIENT, PRADAXA or XARELTO)
   • You have an implanted pacemaker or defibrillator

B. If you are diabetic, please call your diabetes physician for advice on how to regulate your insulin during your colonoscopy prep and on the day of your procedure.

C. Please stop taking the following medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Stop Date Prior to Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin (You may take Tylenol or acetaminophen)</td>
<td>Must be Stopped 7 Days</td>
</tr>
<tr>
<td>Iron</td>
<td>Must be Stopped 3 Days</td>
</tr>
<tr>
<td>Alli (Weight Loss Aid)</td>
<td>Must be Stopped 3 Days</td>
</tr>
<tr>
<td>Ibuprofen, Advil, Aleve, Mobic, Nuprin</td>
<td>Must be Stopped 2 Days</td>
</tr>
<tr>
<td>Arthritis Medicine</td>
<td>Must be Stopped 2 Days</td>
</tr>
</tbody>
</table>

D. Continue using any prescribed inhalers and bring them with you to your appointment.

SUPPLIES
Please purchase the required supplies for colon prep at a pharmacy (available without prescription) at least two days before your procedure

   a. A 10 oz. bottle of Citrate of Magnesia
   b. Two 7 or 8 oz. bottles of MiraLAX powder or generic polyethylene glycol 3350
   c. Gas-X tablets
   d. Two 64 oz. bottles of Gatorade (any color except red, orange or purple)
   e. Diabetic patients: purchase G2 Gatorade in any color
DIET
For three days before your procedure:
• Do not eat corn
• You may have fruits and vegetables but **DO NOT** eat the seeds or peelings
• Do not eat breads or crackers with seeds

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE DAY BEFORE YOUR COLONOSCOPY - NO SOLID FOOD – CLEAR LIQUIDS ONLY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Morning</strong></td>
<td>Clear liquids include: water, cola beverages, coffee, tea, consommé, lemonade, Kool-aid, broth, Gatorade, apple juice, white grape juice, white cranberry juice, Jell-O (any color but red) Drink at least 8 oz. Of these liquids every hour between 8am &amp; 5pm.</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Drink 10 oz. of Citrate of Magnesia Mix one bottle of MiraLAX in each bottle of Gatorade. Shake the solution until the MirLAX dissolves and refrigerate.</td>
</tr>
<tr>
<td>4:00 PM</td>
<td>Take two Gas X tablets</td>
</tr>
<tr>
<td>5:00 PM</td>
<td>Drink one 64 oz bottle of MiraLAX/Gatorade solution. One 8 – 10 oz glass every 10-15 minutes until the bottle is gone. You may continue to drink the liquids listed above until bedtime <strong>but no solid foods.</strong></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE DAY OF YOUR COLONOSCOPY</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Morning** | • **6 hours** before you plan to leave home, begin drinking the remaining bottle of Gatorade/MiraLAX. Drink one 8 –10 oz glass every 10-15 minutes until the bottle is gone. Please make every attempt to finish the bottle. You must finish at least **4 hours** before your appointment time so that your stomach will be empty for the procedure.  
• Do not eat or drink anything else except the Gatorade/MiraLAX the morning of your appointment. Take your necessary medications at least 2 hours prior to the procedure with enough water to swallow the pills.  
• **Under no circumstances can we begin your procedure until at least 2 hours have passed since you ate or drank anything. This includes gum, mints and hard candy.**  
• Do not use chewing tobacco of any kind on the morning of your procedure. |

**ADDITIONAL SUGGESTIONS FOR THE DAY OF YOUR PROCEDURE:**
• Arrive at the designated arrival time so you can be checked in, admitted and changed in time for your procedure
• Do not wear contact lenses if you cannot sleep in them
• Do not wear jewelry
• Wear comfortable clothes that are easy to put back on
• Wear socks to keep your feet warm
• Please do not apply lotion to chest area
Map of Digestive Disease Endoscopy Center
Free Parking in Garage Adjacent to the Building
FREQUENTLY ASKED QUESTIONS

Q: Why do I have to drink half of my prep four hours before I leave home?
A: Studies have also shown that patients that drink ½ of their prep the morning of their procedure better prepared than those who drink it all the night before. Splitting the prep also aids in keeping your sodium at a safe level.

Q: Do I have to take two bottles of MiraLax? I am a small person, and my pharmacist told me I only needed one bottle.
A: The size of a patient has nothing to do with the amount you must take. A small female can have the same length of colon as a large man.

Q: There is not enough room in the Gatorade bottle for all of the MiraLax. What should I do?
A: Pour the Gatorade into a pitcher and then add the MiraLax; or if you do not have a pitcher large enough, pour a little of the Gatorade out and then add the MiraLax.

Q: I cannot take Citrate of Magnesia. Is there anything I can substitute?
A: Citrate of Magnesia works best, but if you cannot drink it, take 4 DulcoLax laxative tablets. Do not substitute the DulcoLax stool softener tablets.

Q: Can I use G2 even if I am not diabetic?
A: Yes, you can use G2. It has less sugar than the regular Gatorade.

Q: Can I take something other than Gatorade?
A: No, Gatorade has the proper electrolytes to prevent the body from absorbing the MiraLax/Gatorade mixture and to keep your body’s electrolytes balanced.

Q: Why can I not take the “pill” prep?
A: The FDA has added a warning to the label of the pill prep that it can cause kidney damage, heart arrhythmias, seizures and even death.

Q: Why can I not drink red Gatorade?
A: When the red color comes through the colon it can look like blood and can hide any bleeding that might be present thus compromising the exam. Red G 2 is fine as the color is less concentrated.

Q: Will I be still going to the bathroom on my drive to your office?
A: You should not have a problem if you start the 2nd half of the prep 6 hours before you leave home but if you are worried, start an hour earlier.

Q: Going to the bathroom so much has made my bottom raw. What can I do about that?
A: Use disposable wet wipes to clean yourself. You should not use any lotion, ointment, or Vaseline before the procedure.

Q: What if I start vomiting while drinking the prep?
A: Skip one dose and slow to half the recommended rate.
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Sex</th>
<th>Birthdate</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>SSN</th>
<th>Employer</th>
</tr>
</thead>
</table>

**Patient Contact Information**

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
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</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Zip</th>
<th>Home</th>
<th>Work</th>
<th>Cell</th>
<th>Email</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Referring Physician</th>
</tr>
</thead>
</table>

- **Marital Status:**
  - ☐ Single
  - ☐ Married
  - ☐ Divorced
  - ☐ Widowed

- **Employment Status:**
  - ☐ Full Time
  - ☐ Part Time
  - ☐ Not Employed
  - ☐ Self Employed
  - ☐ Retired
  - ☐ Military

- **Student Status:**
  - ☐ Full Time
  - ☐ Part Time
  - ☐ Not a Student

**1st Insurance Coverage**

<table>
<thead>
<tr>
<th>Subscriber Name</th>
<th>Insurance Carrier</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birthdate</th>
<th>Sex</th>
<th>Relationship to Patient</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>Group</th>
<th>Group Name</th>
</tr>
</thead>
</table>

**2nd Insurance Coverage**

<table>
<thead>
<tr>
<th>Subscriber Name</th>
<th>Insurance Carrier</th>
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</table>

<table>
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<tr>
<th>Birthdate</th>
<th>Sex</th>
<th>Relationship to Patient</th>
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</table>

<table>
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<tr>
<th>ID</th>
<th>Group</th>
<th>Group Name</th>
</tr>
</thead>
</table>

**Emergency Contact Information**

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<th>Name</th>
<th>Relationship to Patient</th>
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</table>

<table>
<thead>
<tr>
<th>Home</th>
<th>Work</th>
<th>Cell</th>
</tr>
</thead>
</table>

**Appointment Reminder Preference:**

- ☐ Call
- ☐ Text
- ☐ Email

**Please select one of the following:**

- **Race:**
  - ☐ Asian
  - ☐ Native Hawaiian
  - ☐ Other Pacific Islander
  - ☐ African American
  - ☐ Native American
  - ☐ White
  - ☐ More than One Race
  - ☐ Declined to Answer

- **Ethnicity:**
  - ☐ Hispanic/Latino
  - ☐ Not Hispanic/Latino
  - ☐ Declined to Answer

- **Preferred Language:**
  - ☐ English
  - ☐ Spanish
  - ☐ Other
Digestive Disease Endoscopy Center
222 22nd Avenue North, 3rd Floor | Nashville, Tennessee 37203
heritagemedical.com/gastroenterology/ddec

Patient Rights and Responsibilities

You and your family should be as comfortable as possible and know that YOU are our number one concern during your visit to Digestive Disease Endoscopy Center. The following statement of your rights and responsibilities is presented as the policy of this facility, but does not presume to be a complete representation of all-mutual rights and responsibilities.

YOU HAVE THE RIGHT:

- To impartial access to the medical resources of the center without regard to race, color, national origin, age, sex, handicapping or disabling condition, spiritual or ethical beliefs or source of payment.
- To change providers if other qualified providers are available.
- To receive considerate, respectful care, which recognizes your personal dignity at all times and under all circumstances.
- To participate in decisions involving your care. Except in an emergency situation, you shall not be subjected to any procedure without your voluntary, competent and understanding consent or the consent of your legally authorized representative.
- To refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.
- To information about Advance Directives, such as Living Will or Durable Power of Attorney for Health Care, that would allow you to make your own health care decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- To instructional and educational information about your medical treatment in a language and terms that you understand.
- To the confidential treatment of and personal access to your medical record.
- To know who is responsible for providing your direct care and to receive information concerning your continuing health care needs and alternative for meeting those needs.

YOU HAVE THE RESPONSIBILITY:

- To give your doctor and the staff complete and accurate information about your condition and care. To follow instructions of your doctor and the staff of the center and to keep appointments relative to your care.
- To make it known whether you clearly understand planned actions and treatment and what is expected of you.
- To report unexpected changes in your condition to your physician or staff. To accept the financial obligations associated with your care.
- To advise your doctor or any office staff member of any dissatisfaction you may have regarding your care.
- To be considerate of other patients and of staff members who are caring for you.

Center Director: Michael Payne, RN, BSN, MBA 629-255-3152 mpayne@heritagemedical.com

TO REPORT A COMPLAINT CONTACT THE TENNESSEE DEPARTMENT OF HEALTH
“HEALTHCARE FACILITIES COMPLAINT HOTLINE” 1-877-287-0010
OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN
MEDICARE.GOV/CLAIMS-AND-APPEALS/MEDICARE-RIGHTS/GET-HELP/OMBUDSMAN.HTML
Ownership Disclosure: The following physicians are owners of the Endoscopy Center: David McMillen, MD, Joseph Parker, MD, Ryan Roberts, MD, Harrison Shull, MD, and George Wright, MD.

Advance Directives Policy: Based on organization conscience, we will initiate resuscitative and other stabilizing measures in the event you experience a medical emergency. If transferred to a hospital for a higher level of care, a copy of an executed advance directive, if received, will be sent as part of your transfer packet.

Do you have a living will or Durable Power of Attorney? Yes ___ No ___
I am providing a copy to the Ambulatory Surgical Center Yes ___ No ___

I have received information about:
Advanced Directives/Honoring Advance Directives (Initial) ___
Patient Rights and Responsibilities (Initial) ___
Physician Ownership of the Endoscopy Center (Initial) ___

Financial Policy

Insurance and Fees: Please provide your current insurance information when you schedule your appointment and bring proof of your insurance with each visit. If you have any questions about our charges or your bill, please call our billing office at 615-284-3880.

Collection of Co-Payments and Payments of your Bill: Payment of all known deductibles, co-payments, coinsurance, outstanding balances and non-covered services will be required at the time service is rendered. Patients who do not have proof of insurance will be responsible for full payment at the time of service. For out-of-network patients, we require full payment at the time of the service but we will file your insurance claims for reimbursement on your behalf as a courtesy.

Billing Notification: You will receive three billing statements for services rendered to you during your procedure.
Professional services provided by your physician will be billed by Heritage Medical Associates. If you have questions regarding the physician’s professional fee please call 629-255-3880.
You will receive a separate statement from Digestive Disease Endoscopy Center for services provided by the center’s staff and for medical equipment and supplies utilized during your procedure. If you have questions please call 615 340-4625.
Anesthesia for your procedure at Digestive Disease Endoscopy Center will be provided by DDEC Anesthesia, LLC. Anesthesia services are billed separately to your insurance. You will receive a billing statement for your balance due once we have received correct payment from your insurance. Please call 1 866 556-8824 for any questions relating to your anesthesia billing statement.
In the event that biopsies are taken and/or polyps are removed you will also receive a separate billing statement from the pathology provider.

Payment Options for Payments: We accept Cash, Check, Visa, MasterCard, Discover and American Express. There is a $25.00 returned check fee for all checks returned for insufficient funds. Post-dated checks will not be accepted.

Past Due Balances: We require that past due balances be paid, in full, prior to a subsequent office visit.

Outstanding balances may result in dismissal from the practice: If you are unable to make payment, please contact our Business Office at 629-255-3474. In the event an account is placed with a collection agency, you will be responsible for the 30% collection fee, court costs and legal fees.

Missed Appointment Policy: Should you need to cancel or reschedule your appointment we ask that you advise us a minimum of 48 hours in advance of your scheduled appointment. Failure to notify the office could result in a charge of $250.00 to your account. Multiple missed appointments may result in dismissal from the practice. If you arrive late you may be asked to reschedule your appointment.

I hereby authorize my insurance benefits to be paid directly to Digestive Disease Endoscopy Center, realizing I am responsible to pay non-covered services and deductibles. I hereby authorize the release of pertinent medical information to insurance carriers.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Patient Name (Print) __________________________ Date __________________________
Patient/Representative Signature __________________________ Relationship to Patient __________________________
Please answer all questions, as this will become part of your medical history.

<table>
<thead>
<tr>
<th>Drug Allergies</th>
<th>No known drug allergies</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reaction</th>
<th>Drug</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>6.</td>
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<td>2.</td>
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<td>5.</td>
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What is the chief symptom or problem for which you have come to be evaluated?
____________________________________________________________________________

Please list any additional or associated symptoms you are having with this illness:
____________________________________________________________________________

When did the problem begin? _________________________________________________

Please report any unusual circumstances or events at the time the problem began:
____________________________________________________________________________

How severe are your symptoms?  ______________________________________________

Are your symptoms intermittent or continuous? _________________________________

How often do you experience these symptoms?  _________________________________

How long do the symptoms last?  ______________________________________________

When or under what circumstances do you experience symptoms?
____________________________________________________________________________

What brings on or aggravates your symptoms?
(e.g. eating, bowel movements, specific positions, activities, stress…)
____________________________________________________________________________

What helps relieve your symptoms?
(e.g. eating, bowel movements, specific positions, relaxation, medicines…)
____________________________________________________________________________

Is the severity or frequency of your symptoms worsening, stable or improving?
____________________________________________________________________________

Please indicate on the diagram where your symptoms are located:
If the problem has been pain, how would you describe its character (e.g. burning, cramping, dull, sharp etc.)

What diagnostic tests or procedures have been done and what were the results?
1. ________________________________________________ 3. ________________________________________________
2. ________________________________________________ 4. ________________________________________________

What medicines or treatments have you tried and did they help?
1. ________________________________________________ 3. ________________________________________________
2. ________________________________________________ 4. ________________________________________________

Please list all your other current medical problems and diagnoses.
1. ________________________________________________ 3. ________________________________________________
2. ________________________________________________ 4. ________________________________________________

Please list all your current medications, dosages and how often you take them. Please print or bring medicines with you to your appointment.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength</th>
<th>How Often</th>
<th>Drug</th>
<th>Strength</th>
<th>How Often</th>
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Pharmacy Name ______________________________________________________ Pharmacy Zip ___________________

**Past Medical History**
Surgical Operations and Hospitalizations

________________________________________________________________________________________

________________________________________________________________________________________

Have you ever had a colonoscopy or upper endoscopy? ☐ Yes ☐ No
Have you had colon polyps in the past? ☐ Yes ☐ No
Have you had colon cancer? ☐ Yes ☐ No
Have you ever had an ulcer? ☐ Yes ☐ No
Have you ever been given a blood transfusion? ☐ Yes If yes, when? ____________

Have you been diagnosed with:
☐ Hepatitis ☐ Ulcerative Colitis ☐ Crohn’s Disease ☐ Pancreatitis ☐ Barrett’s Esophagus
Do you have a pacemaker / defibrillator? ☐ Yes If yes, who placed it? ________________
Family History
Which of your relatives (if any) have had the following conditions?

☐ Colon Cancer  Family Member ___________________________  At what age? ________
☐ Colon Polyps  Family Member ___________________________  At what age? ________
☐ Ulcerative Colitis  Family Member ___________________________
☐ Crohn’s Disease  Family Member ___________________________
☐ Liver Disease / Cirrhosis  Family Member ___________________________
☐ Pancreatic Cancer / Pancreatitis  Family Member ___________________________
☐ Other Diseases in Family ___________________________________________________________________

Social History / Personal Information
What is your marital status?  ☐ Single  ☐ Married  ☐ Divorced  ☐ Widowed
How many children do you have?  ________________________________
What is your occupation?  _________________________________________
Have you been under an unusually large amount of stress lately?  ☐ Yes  ☐ No

Tobacco Use:  ☐ Never Smoked  ☐ Current Smoker  ☐ Previous Smoker  ☐ Current Chew / Dip
Pack / Day ________  Year Quit ________

Alcohol Use:  ☐ Yes  ☐ No  Drinks / Day ________

Are you an Organ Donor:  ☐ Yes  ☐ No

Review of Systems
Please check if you have RECENTLY had any of the following:

☐ Fever  ☐ Constipation  ☐ Musculoskeletal
☐ Weight Gain (Amount ________)  ☐ Diarrhea  ☐ Joint Pain
☐ Weight Loss (Amount ________)  ☐ Difficulty Swallowing  ☐ Neurological
☐ Eyes  ☐ Indigestion (Upper Abdomen Pain)  ☐ Seizures
☐ Eye Irritation  ☐ Jaundice (Yellow Skin)  ☐ Stroke
☐ Respiratory  ☐ Nausea / Vomiting  ☐ Psychiatric
☐ Cough  ☐ Change in Bowel Habits  ☐ Feeling of Depression
☐ Wheezing  ☐ Reflux  ☐ Substance Abuse / Dependence
☐ Cardiovascular  ☐ Vomiting Blood  ☐ Endocrine
☐ Chest Pain  ☐ Other Abdominal Pain  ☐ Diabetes
☐ High Blood Pressure  ☐ Hematology
☐ Gastroenterology  ☐ Urinary Tract
☐ Black, Tarry Stool  ☐ Difficult or Painful Urination
☐ Bloody Stool  ☐ Kidney Stone (or any insufficiency)

Physician Use Only

<table>
<thead>
<tr>
<th>Review of Systems</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart, Rate and Rhythm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician Signature __________________________________________ Date ________________