Westside Endoscopy Center, P.C.

3825 Medical Park Drive SW
Suite 300
Austell, GA 30106-1109

Phone: (770) 941-4810
Fax: (770) 948-9149

Thank you for choosing Westside Gastroenterology Associates for your GI care.

Please be sure to follow the instructions carefully to ensure that your procedure is successful. If you do not follow the instructions, you risk having your procedure delayed or rescheduled for another time. If you have any questions please contact the staff at 770-941-4810. Remember, in case of an emergency, you can call the office number above and the answering service will get in touch with Dr. Jasmine Jeffers.

Please read and fill out this package that has been given to you. This package includes:

1. Understanding Your Financial Obligations.
   Cancellation notification – you must cancel 5 weekdays in advance to avoid a **$250** dollar cancelation fee; this frees up the time slot to be used for another patient.
2. Informed Consent for Endoscopy Services.
3. Consent for Anesthesia Services.
4. Medication reconciliation – **please list ALL of your medications**, including over-the-counter or nonprescription medications and supplements.
5. Release of Information.
6. Advance Directive.
7. Escort information – please write the name and phone number of the person who will drive you home; remember that your escort must be with you when you check in at your appointment time.
8. Patient Rights and Responsibilities.

REV: 07/2024

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UNDERSTANDING YOUR FINANCIAL OBLIGATIONS

FORM MUST BE COMPLETED IN FULL

Patient Name:_____ **DOB**:_____ **Date**:_____

Procedure Date:_____ **Arrival Time**: _____ : _____

Our physicians have scheduled you for an endoscopic procedure. This document explains your financial obligations. If you have any questions, please feel free to contact the office at 770-941-4810.

PRIOR AUTHORIZATION

As a courtesy to our patients, our office will pre-certify procedures performed at our endoscopy center, with your insurance company. If there is an upfront amount due for the facility and physician portion, you will be notified of this amount owed via a phone call. **It is your responsibility to verify benefits with your insurance company prior to having the procedure.** For example, if you are having a screening colonoscopy because of family history of colon cancer or personal history of colon polyps, you definitely need to verify coverage because all insurance plans are different.

EXPECTED FEES

The following fees can be expected when having a procedure at **Westside Endoscopy Center, P.C.**:

- **PHYSICIAN FEE:** You will receive a bill from **Westside Gastroenterology Associates** for the physician's charge of the procedure. The amount owed is the patient's responsibility after insurance processed.
- **FACILITY FEE:** This is the place of service fee for the surgical facility. The statement will come from **Westside Endoscopy Center, P.C.** The amount owed is the patient's responsibility after insurance has been processed.
- **PATHOLOGY FEE:** If polyps or biopsies are removed you may also receive a bill for pathology services. Our Endoscopy Center has partnered with **QDx Pathology Services,** to process and exam the specimen(s). **QDx Pathology Services,** will treat your claim as In-network even if your EOB states that your insurance provider treats it as "out-of- network". The only time you should pay **QDx Pathology Services,** is if you receive a bill statement from them. If you have any question about your pathology bill, please contact **QDx Pathology Services,** billing department at **1-866-909-7284.**
- **ANESTHESIA FEE:** Fee to cover anesthesia and vital signs monitoring. This statement will come from **SouthCare Anesthesia Services, LLC**, and the amount owed is patient's responsibility after insurance has been processed. Patients with no insurance coverage will be expected to pay at the current self-pay rate. If you have any questions concerning your anesthesia bill, please contact our billing office, toll free number at **1-844-469-4936.**

CANCELLATION POLICY

The center is staffed by an anesthesiologist, RN's and surgical assistants. If you need to change your appointment date, please do so **no later than 48 hours prior** to your scheduled date so that the time allotted can be utilized by another patient. If you fail to do so barring an emergency, **YOU** (not your insurance company) will be responsible for a cancellation/no show fee of **$250.** You will receive a confirmation call within five days before your procedure.

*By signing below, I understand the billing practices of **Westside Gastroenterology Associates (WGA) Westside Endoscopy Center, P.C. (WEC)** and **SouthCare Anesthesia Services, LLC (SAS)** and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to **WGA, WEC** and **SAS** and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan.*

Patient/Guarantor Signature*_____ Date:_____

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INFORMED CONSENT: ENDOSCOPY SERVICES

FORM MUST BE COMPLETED IN FULL

Patient Name:_____ **DOB**:_____ **Date**:_____

Gastrointestinal endoscopy is direct visualization of the digestive tract or abdominal cavity with lighted instruments. At the time of your examination, the inside lining of the digestive tract will be inspected and possibly photographed. If an abnormality is seen, or suspected, a small portion of tissue may be removed for microscopic study (biopsy), or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths (polyps) can frequently be removed (polypectomy). Occasionally, during the examination a narrowed portion (stricture) will be stretched (dilation) to a more normal size.

I acknowledge that I will undergo the following procedures, which I have INITIALED below, and have been described to me. I hereby voluntarily authorize Dr. Jasmine Jeffers and such assistants, as may be selected by her, to perform the following:

Please initial on the line beside the procedure you are having AND the line beside IV Sedation, Monitored Anesthesia Care ("MAC").

INITIAL

_____ **Esophagogastroduodenoscopy (EGD)**

Examination of the esophagus, stomach and duodenum (small intestine). Biopsies, photographs, collection of cytology and/or other specimens, removal of polyps or tumors, endoscopic treatment of bleeding lesions (such as cautery, injection or banding), and dilation of strictures may be obtained/ performed during this examination.

_____**Colonoscopy/Flexible Sigmoidoscopy**

Examination of all or a portion of the colon (large intestine). Biopsies, removal of polyps, electrocoagulation (cautery), injection of medications into bleeding lesions and specimen collections may be obtained/ performed.

_____ **IV Sedation or MAC**

Intravenous administration of agents to produce the desired effect of relaxation. Selection of the type of anesthesia is based on the proposed procedure.

_____ **For Women of Childbearing Age**

I certify that I am not pregnant or breast feeding at this time and I am aware of the risks of sedation to an unborn child.

KNOWN RISKS OF THESE PROCEDURES

- Injury to the lining of the digestive tract caused by the instrument, which may result in the perforation of the wall and leakage into the body cavities. If this occurs, a surgical procedure to close the leak and drain the region is often necessary.
- Bleeding may be a complication of biopsy, polypectomy, dilation or any other instrumentation. This complication may require only careful observation or may require transfusion or possibly a surgical procedure.
- There are additional risks such as drug reactions, heart rhythm disturbances, and complications incidental to other disease(s) you may have.

Patient Name:_____ **DOB**:_____ **Date**:_____

- Other risks include: death, respiratory arrest, cardiac arrest, brain damage, disfiguring scar, paraplegia or quadriplegia, (paralysis or partial paralysis), loss of function of any limb or organ, severe loss of blood, allergic reaction and infection.
- Material risks of Intravenous Sedation include, but are not limited to infection, allergic reactions, loss of blood, injury or miscarriage of unborn child, loss of function of any limb or organ system, (such as heart, lungs, liver, kidney) paralysis, cardiac arrest and death.

PATHOLOGY

- Any tissue or specimens obtained during the procedure may be retained, preserved or disposed of by, or under the direction of the pathology department examining the specimen(s).
- In the event a staff member is accidentally exposed to any of my bodily fluids, I authorize testing of my blood for HIV, and Hepatitis B and C.

In conjunction with the procedure identified above, I acknowledge that I have been informed in general terms of the following:

- Diagnosis of the condition requiring procedure
- Nature and purpose of the procedure
- Material risks of the procedure
- Practical alternative to procedure
- Prognosis if procedure is rejected
- Likelihood of success of procedure

I understand the above information regarding endoscopy and acknowledge that I have been informed of the risks and possible complications. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s) identified above. If any unforeseen condition arises during the procedure(s) calling for additional procedures, operations, or medications including anesthesia and blood transfusion, I further request and authorize the physician to do whatever she/he deems advisable in my interest. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

_____ _____
PATIENT SIGNATURE DATE SIGNED

Authorized Personal Representative:_____
PRINT NAME SIGNATURE

Please indicate relationship to patient:_____

_____ _____
PHYSICIAN SIGNATURE DATE SIGNED

_____ _____
WITNESS SIGNATURE DATE SIGNED

SouthCare Anesthesia Services, LLC
P.O. Box 673
Austell, Georgia 30168
(770) 941-4810

CONSENT FOR ANESTHESIA SERVICES

Patient Name:_____ **DOB**:_____ **Date**:_____

I _____ (patient name), acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are recommended so that my doctor can perform the operation/ procedure.

It has been explained to me that all forms of anesthesia involve some risks, and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complication with anesthesia can occur and include the remote possibility of: **infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function or paralysis, stroke, brain damage, heart attack or death.** I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the types(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to perform, his/ her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

□**General Anesthesia**	**Expected Result**	Total unconscious state, possible placement of tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
☒**Monitored Anesthesia Care** (with deep sedation)	**Expected Result**	Reduce anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
□**Monitored Anesthesia Care** (without sedation)	**Expected Result**	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks	Increased awareness, anxiety and/or discomfort.

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

_____ _____
PATIENT SIGNATURE DATE & TIME

_____ _____
SOUTHCARE ANESTHESIA SERVICES – WITNESS SIGNATURE DATE & TIME

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MEDICATION RECONCILIATION RECORD

Patient Name:_____ **DOB**:_____ **Date**:_____

ALLERGIES: *drugs, foods, substances, latex, etc.*

Allergic to:	Describe reaction:

CURRENT MEDICATIONS: *List all of the patient's medications prior to procedure including those prescribed, over-the-counter, samples, vitamins, supplements, respiratory therapy-related (inhalers) and herbal meds.*

Medication:	Dose:	Frequency:

_____ _____ _____

Pre-Op Interviewing RN Sign & Date | **Admitting RN Sign & Date** | **Physician Sign & Date**

NEW MEDICATIONS PRESCRIBED:

Medication:	Dose:	Frequency:

DISCLAIMER: This list is provided to you by the facility as an educational tool. We have noted all the medications you are currently taking including the medication(s) we have prescribed. The list is prepared based on the information you have provided to us. This Center is not responsible to maintain, prescribe or refill any of the above medication(s).

_____ _____ _____

Discharging RN Sign & Date | **Patient Signature** | **Companion Signature**

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RELEASE OF INFORMATION

FORM MUST BE COMPLETED IN FULL

Patient Name:_____ **DOB**:_____ **Date**:_____

I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits payable for related services.

I hereby authorize the release of any confidential information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization, review or quality assurance activities, or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **WESTSIDE ENDOSCOPY CENTER, P.C.** for all medical and/ or surgical benefits including major medical policies to which I am entitled under any insurance policy or policies, any self-insurance program or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility including, but not limited to, payment of those fees and charges not directly reimbursed to **WESTSIDE ENDOSCOPY CENTER, P.C.** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing, a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

HOW WE WILL PROTECT YOUR PRIVATE HEALTH INFORMATION

When you visit our Center it is very important that you feel safe; your personal information may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice always has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. On April 14, 2003 new regulations became effective under federal law called *Health Insurance Portability and Accountability Act (HIPPA)*. HIPPA regulations cover physicians and all other health care providers, health insurance companies and their claims processing. In general, HIPPA was enacted to establish national standards to:

- Give patients more control over their health information.
- Set boundaries for the use and release of health records.
- Establish safeguards that physicians, health plans, and other healthcare providers must have in place to protect the privacy of health information.
- Hold violators accountable with civil and criminal penalties.
- Try to balance the need for individual privacy with the requirements for public responsibility that requires disclosures to protect the Public health.

AUTHORIZATION TO DISCUSS RESULTS

You will be sedated for your procedure. Therefore, it will be necessary to review your discharge instructions with your escort. If you desire, we will also discuss procedure findings with your escort.

Please initial below if you agree to these terms.

_____ I agree that the staff at **WEC** can discuss home care instruction with my escort.

_____ I agree for the staff at **WEC** to discuss procedure findings with my escort.

You will receive a call after your procedure from a nurse to see how you are doing. Please tell us how we are authorized to contact you:

□ Home □ Work □ May leave a message □ May discuss with family members who may answer the phone

Patient/Guarantor Signature*_____ Date:_____

WESTSIDE ENDOSCOPY CENTER P.C. is wholly owned and operated by Jasmine G. Jeffers, M.D.

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ADVANCE DIRECTIVE

Patient Name:_____ **DOB**:_____ **Date**:_____

The ***1990 Patient Self-Determination Act*** is a federal law that says patients must be informed of their rights under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to have an advance directive. **The advance directive document is a way for you to communicate what kinds of medical care and treatment you do or do not want if you become unable to make these decisions for yourself.**

A written advance directive can communicate a competent person's wishes regarding health care, including life prolonging treatment. The directive can designate a person who will have the role of making difficult health care decisions for you, if you become unable to state your wishes. A formal advance directive can be in the form of a living will, a life-prolonging procedures declaration, an appointment of a health care representative, or an appointment of a power-of-attorney for health care. You have a right to make an advance directive if you want to, but you are not required to do so. If you wish, we will provide you with an Advance Directive form. You can obtain a copy from the following sites:

http://www.gha.org/publication/other/AdvanceDirective .pdf
www.gabar.org/public/docs/Form GerogiaAdvanceDirectiveforHealthCare.doc

Medical Association of Georgia,
938 Peachtree St.
Atlanta, GA 30309

Ambulatory Surgery Centers including WESTSIDE ENDOSCOPY CENTER, P.C. are exempt from honoring Advance Directives.

Patient/Guarantor Signature*_____ Date:_____

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PROCEDURE ESCORT ACKNOWLEDGMENT

ABOUT SEDATION

- You will be sedated for your procedure. You will feel wide awake following your procedure but there may be lingering effects from sedation that may affect your ability to follow instructions and to make decisions for the remainder of the day.
- You will need a responsible adult to escort you to and from the procedure unit.
- Do not drive, operate machinery or make important decisions for the remainder of the day.
- Do not use alcohol, marijuana or other substances for the remainder of the day.
- Plan to rest at home for the remainder of the day.

YOUR ESCORT MUST:

- ARRIVE WITH YOU
- SIGN IN
- LEAVE HIS/HER CONTACT INFORMATION
- ARRIVE PROMTLY DOWNSTAIRS FOR PICK UP WHEN NOTIFIED

NOTE

If you do not have a competent driver present with you, your procedure will be CANCELLED and you will be subject to a cancellation fee of $250.00.

By signing below, I acknowledge that I must arrive to my procedure with an escort who will drive me home afterwards. If I were to arrive without an escort, my appointment will be cancelled and I am subject to pay a cancellation fee.

Patient/Guarantor Signature:_____ Date:_____

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PATIENT RIGHTS & RESPONSIBILITIES

Patient Name:_____ **DOB**:_____ **Date**:_____

PATIENT RIGHTS

1. The Center is owned by Jasmine Jeffers, M.D. of the affiliated Medical Practice. All other physicians affiliated with the Medical Practice have Center privileges. Patients have the right to choose another facility for his/her procedure. The patient will be provided a copy of the Patient Rights and Responsibilities prior to the date of the procedure. The provision of this form is delegated to the Medical Practice which shall provide a copy of the signed and dated form to the Center prior to the procedure.
2. Some or all of the health care professionals performing services in this Center are independent contractors and are not Center agents or employees. Independent contractors are responsible for their own actions and the Center shall not be liable for the acts or omissions of any such independent contractor.
3. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
4. Patients shall receive assistance in a prompt, courteous, and responsible manner.
5. Patient disclosures and medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.
6. Patients have the right to know the identity and status of individuals providing services to them.
7. Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patients' stay.
8. Patients, or a legally authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
9. When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their
11. healthcare.
12. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
13. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
14. Patients have the right to make suggestions or express complaints about the care they have received and to submit such to the Administrative Director who will complete an "Incident Notification" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.
15. Patients have the right to be provided with information regarding emergency and after-hours care.
16. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
17. Patients have the right to a safe and pleasant environment during their stay.
18. Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
19. Patients have the right to have procedures performed in the most painless way possible.
20. Patients have the right to an interpreter if required.
21. Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
22. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Center and its staff.
23. Patients have the right to have copies of their "Advance Directives" and "Living Wills' in their medical records.

Patient Name:_____ **DOB**:_____ **Date**:_____

24. In the event of an emergency, the patient will be transferred to the appropriate facility which will be notified of such "Advance Directives" and/or "Living Wills".
25. Patients will be provided, upon request, all available information regarding services available at the Center, as well as, information about estimated fees and options for payment.
26. If applicable, patients will be informed of the absence of malpractice insurance coverage.
27. Patients have the right to approve the release of their medical records to other care providers, legal representatives and other persons authorized by the patient.
28. Patient has the right to exercise his/her rights without being subject to discrimination or reprisal.

PATIENT RESPONSIBILITIES

1. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products and dietary supplements and any allergies or sensitivities.
2. Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
3. Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
4. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
5. Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Administrative Director.
6. Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.
7. Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.
8. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
9. Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.
10. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care. In the event of an emergency, the patient will be transferred to the appropriate facility. The facility will be notified of the existence of the Advance Directive, if applicable, and will be provided with a copy.
11. Patients are responsible for having a responsible adult transport them from the Center and remain with the patient for twenty-four (24) hours, if required by the Physician.
12. The patient will be provided a copy of the Patient Rights and Responsibilities prior to the date of the procedure.
13. The provision of this form is delegated to the Medical Practice which shall provide a copy of the signed and dated form to the Center prior to the procedure.

QUESTIONS or CONCERNS?

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. Discuss your concerns with your doctor, nurse, or other caregiver, or you contact the Administrator at (770) 941-4810, or westmed1@bellsouth.net.

Should you continue to remain concerned you may contact the Georgia Department of Community Health at (404) 657-5434 or at 2 Peachtree Street, Suite 31-447, Atlanta, Georgia, 30303-3142, or your Ombudsman at (770) 427-0880 or at: www.cms.hhs.gov/center/ombudsman.asp

Patient/Guarantor Signature*_____ Date:_____