NORTHSIDE GASTROENTEROLOGY SCHEDULING HEALTH HISTORY FORM

Please complete this form at least 1 week prior to your scheduled procedure in order for us to determine if you need to speak with our pre-call nurse. Bring this form with you the day of your procedure.

Patient Name: _____ DOB: _____ Phone: _____

Name/Relationship of driver to patient: _____

Driver's phone #: _____

May we discuss your healthcare with your driver? Y or N

Current height: _____ Current weight: _____ BMI: _____

(We will calculate)

Reason for procedure: _____

HEALTH HISTORY

Question	Y	N
Have you had a heart attack or stent placement within the last 6 months?		
Do you have any heart conditions such as a murmur or an abnormal heart rhythm?		
Have you experienced recent chest pain or unusual shortness of breath?		
Do you have any pending heart tests?		
Do you have a pacemaker WITH a defibrillator?		
Have you had a respiratory illness within 2 weeks of your scheduled procedure?		
Do you use oxygen at home and/or use it "as needed?"		
Have you been diagnosed with diverticulitis or C-Diff infections in the last 2 weeks?		
Are you currently taking a GLP1 and/or medication for weight loss?		
Are you currently receiving or have a dialysis treatment scheduled?		
In the last 90 days, have you had a TIA or stroke?		
Are you currently taking a prescribed blood thinner medication?		
Do you have a seizure disorder? If so, have you had a seizure in the last 3 months?		
After a prior surgery, have you ever been told you have a difficult airway?		
Have you or an immediate family member had difficulty with anesthesia?		
Have you had head, neck, or vocal cord surgery and/or radiation to the head/neck?		
Have you experienced an anaphylactic (life threatening) reaction to latex?		
Have you had heart or abdominal surgery in the last 2 months?		
Have you had a blood clot or pulmonary embolism in the last 90 days?		
Are you able to move your neck side to side and touch your chin to your chest?		

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS IN THE HEALTH HISTORY SECTION ON PAGE 1, PLEASE CALL 317-224-0167 TO AVOID POSSIBLE CANCELLATION OF YOUR PROCEDURE.

ADDITIONAL HEALTH HISTORY QUESTIONS

Question	Y	N
Are you followed regularly by a cardiologist? If so, date last seen:		
Do you have diagnosed sleep apnea?		
Do you use a CPAP machine or similar device?		
Do you have asthma?		
Do you use inhalers?		
Do you have reflux or heartburn?		
Do you have difficulty swallowing and/or food/liquid becoming stuck in your throat?		
Are you currently anemic? (i.e. low iron or hemoglobin)		
Have you ever been diagnosed with cancer (including skin)?		
If you've had cancer, list the type, date of diagnosis & treatment:		
Have you been diagnosed with diabetes?		
If you've been diagnosed with diabetes list the type & your last A1C:		
Do you have liver or thyroid disease?		
Do you have kidney disease?		

DO YOU CURRENTLY OR HAVE YOU PREVIOUSLY USED THE FOLLOWING:

Tobacco: Amount _____ Duration _____ Quit date _____

Alcohol: Amount _____ Quit date _____

Recreational drugs: Amount _____ Frequency _____ Quit date _____

PLEASE LIST MEDICATION, FOOD, & OTHER ALLERGIES

_____

LIST ALL SURGERIES FROM CHILDHOOD TO PRESENT

_____

_____

LIST MEDICATIONS (INCLUDING HERBAL MEDICINE AND SUPPLEMENTS)

Medication	Dosage	Route	Frequency	Date last taken

Northside Gastroenterology Endoscopy Center
8424 Naab Rd 3-G
Indianapolis, In 46260
317-871-7308

PLEASE BRING THIS PAPER WITH YOU TO YOUR APPOINTMENT

It is your responsibility to discuss benefits and networks with your insurance company as well as your history of polyps and/or family history. All National Provider IDs are listed to check networks. Base CPT code for colonoscopy is 45378. Base CPT code for EGD is 43235. Our office takes responsibility for authorizations only.

After insurance is filed, if used, you **may** be receiving a bill from:

Northside Gastroenterology Endoscopy Center, LLC for facility
NPI 1659344133

Northside Gastroenterology Inc. P.C. for doctor and pathology
NPI 1568578201

AmSurg Indianapolis Anesthesia, LLC for anesthesia
NPI 1487056388

**If anesthesia is OUT OF NETWORK, you should pay no more than $500 out of pocket.

**You may also receive a bill from Ameripath for slide preparation for pathology.
They are in network with most all insurance companies.

**If you experience a change in insurance contact our office immediately as that can affect your authorization and delay procedure.

**This procedure could cost on average $1500-$2000 based on normal, with insurance, if deductible not met.

I understand that I am ultimately responsible for any remaining balance whether paid by insurance.

_____ _____
Name Date

Your signature acknowledges that you have been made aware of our billing practices.

Northside Gastroenterology Endoscopy Center

PATIENT REGISTRATION/RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Referring Doctor: _____ PCP: _____

Email Address: _____

Pharmacy Name: _____ Pharmacy #: _____

Pharmacy Address: _____

Mail Order Pharmacy Name: _____ Phone #: _____ Fax #: _____

_____

I give permission to Northside Gastroenterology Endoscopy Center to discuss my personal, medical, or financial information…

If we contact you for a follow-up call:

Which phone number would you like us to call? _____

Home Work Mobile Other

May we leave a message if you do not answer? Yes No

May we leave to anyone else that might answer? Yes No

Due to HIPAA rules and regulations, we are not allowed to release any of your medical information (test results, lab results, information regarding appointments, insurance claims, or any other information regarding your file) to anyone, not even family members, unless we have your written permission.

Please list individuals (excluding physicians) we can speak with regarding your care:

_____ _____

_____ _____

THIS INFORMATION WILL BE SHARED WITH NORTHSIDE GASTROENTEROLOGY, INC.

X _____ Date: _____

PATIENT RIGHTS BROCHURE

Northside Gastroenterology Endoscopy Center

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

Every patient has the right to be treated as an individual and to actively participate in and make informed decisions regarding his/her care. The facility and medical staff have adopted the following list of patient's rights and responsibilities, which are communicated to each patient, or patient's representative/surrogate in advance of the procedure.

Patient Rights:

Every patient of a facility shall have the right:

a) To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

b) To receive considerate, respectful and dignified care.

c) To be provided privacy and security during the delivery of patient care service.

d) To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

e) To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

f) When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

g) To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.

h) To be free from mental and physical abuse, or exploitation during the course of patient care.

i)All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse will be fully documented and these allegations will be reported immediately to the Center Leader or their designee. Substantiated allegations will be reported to the State authority or the local authority or both.

j) Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

k) Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

l) To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.

m) Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.

u) To appropriate assessment and management of pain.

v) To be advised if the physician providing care has a financial interest in the surgery center.

Patient Responsibilities:

▪To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

▪To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.

▪To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.

▪To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.

▪To accept personal financial responsibility for any charges not covered by their insurance.

▪ To be respectful of all the healthcare professional and staff as well as other patients.

If you need an Interpreter:

If you will need an interpreter, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

•Exercise his or her rights without being subjected to discrimination or reprisal

•Voice grievance regarding treatment or care that is or fails to be furnished

•Be fully informed about a treatment or procedure and the expected outcome before it is performed

•Confidentiality of personal medical information

Privacy and Safety ***The patient has the right to:***

•Personal privacy

•Receive care in a safe setting

•Be free from all forms of abuse or harassment

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Indiana Code 16-36. In the state of Indiana, a patient has the right to have spoken and written instructions about their future medical care and treatment. An advance directive may name a person of their choice to make health care choices for them when they cannot make the choices for themselves or to prevent certain

Advance Directives cont.

Northside Gastroenterology Endoscopy Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution, You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Center Administrator
8424 Naab Rd. Suite 3-G
Indianapolis, IN 46260
Phone 317-871-7308

You may contact the state to report a complaint;
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
Phone: 317.233.1325

State Web site: http://www.in.gov/isdh/

Medicare Ombudsman website
https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

Accreditation Association for Ambulatory Health Care (AAAHC)
3 Parkway North, Suite 201
Deerfield, IL 60015
847.853.6060
info@aaahc.org

PATIENT RIGHTS BROCHURE

Northside Gastroenterology Endoscopy Center

n) Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
o) To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
p) To be informed of the right to change providers if one is available
q) To know which facility rules and policies apply to his/her conduct while a patient.
r) To have all patients' rights apply to the person appointed under State law to act on the patient's behalf when the patient is adjudged incompetent and when the court has not adjudged the patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
s) To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
t) To examine and receive an explanation of his/her bill regardless of source of payment.

people from making health care decisions on their behalf.
http://www.in.gov/isdh/25880.htm
You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Northside Gastroenterology Endoscopy Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Northside Gastroenterology Endoscopy Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Northside Gastroenterology Endoscopy Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.
Northside Gastroenterology Endoscopy Center遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Physician Financial Interest and Ownership:
The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

Fyeza Haider, MD
Lawrence Born, MD
Taiseer Shatara, MD
Arthur Baluyut, MD
Mark Scheidler, MD
Spencer Wilson, MD

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