READ ONLY

SCREENING FOR AEROSOL TRANSMISSIBLE DISEASES (ATD)

In compliance with California OSHA Title 8, Section 5199, health care facilities must prescreen patients for aerosol transmissible diseases. If you have any of the following, please circle, if none apply please check "NO"

Do you have (circle):

1. History of Tuberculosis (Productive cough, Bloody Sputum, Fever, Malaise, Night Sweats, Unexplained Weight Loss). **NO____**

2. Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis (Body Aches, Runny Nose, Sore Throat, Nausea, Vomiting, Diarrhea, Fever & Respiratory Symptoms, Severe Coughing Spasms, painful-swollen Glands, Skin Rash-blisters, Stiff Neck) **NO____**

3. Chronic Respiratory Diseases (NOT ATD'S and not considered infectious) do not disqualify a patient from treatment. **Do you have (circle)**: Chronic upper airway cough syndrome "postnasal drip", Gastro esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), Bronchitis, Emphysema, Allergies, Asthma. **NO____**

_____ _____

PATIENT'S SIGNATURE **DATE**

PATIENT NAME:
(PLEASE PRINT)
DOB:

READ ONLY

ENDOSCOPY CENTER OF SOUTHERN CALIFORNIA
2336 SANTA MONICA BLVD SUITE # 204
SANTA MONICA, CA. 90404

GASTROINTESTINAL ENDOSCOPY INFORMATION AND CONSENT FORM

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for, and possible risks of these procedures.

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

The following are the principal risks of these procedures:

1. Injury to the lining of the digestive tract by the instrument which may result in perforation of the wall and leakage into body cavities; if this occurs, surgical operation to close the leak and drain the region is often necessary.

2. Bleeding, if it occurs, usually is a complication of biopsy, polypectomy, or dilation; management of this complication may consist only in careful observation or may require blood transfusion or possibly a surgical operation for control.

   Other risks include drug reactions and complications incident to other diseases you may have. You should inform your physician of all your allergic tendencies and medical problems. Other complications are irregular heart rate (too low or too high), depressed breathing, splenic injury, aspiration, missed lesions, lowered blood pressure, damage to teeth and dental appliances, and rarely death. All of these complications are possible but occur with a very low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for gastrointestinal endoscopy.

A brief description of each endoscopic procedure follows:

(1) Colonoscopy: examination of all or a portion of the colon requiring careful preparation with diet and medication. Patients with previous pelvic surgery and those with extensive diverticulosis may be more prone to complications.

(2) Colonoscopy with Polypectomy: performed as above (1), using a wire loop and electric current to remove small growths that protrude into the colon.

I certify that I have read the above and I understand the information regarding gastrointestinal endoscopy and that I have been fully informed of the risks and possible complications thereof. I consent to the taking and reproduction of any photographs in the course of this procedure for professional purposes. I hereby authorize and permit and whomever he may designate as his assistants to perform upon me the following procedure:

COLONOSCOPY WITH POSSIBLE BIOPSY AND POSSIBLE POLYPECTOMY, POSSIBLE BANDING OF HEMORRHOIDS

Addendum "A"
-I will not drive or operate appliances or machinery that requires quick reaction time.
-I will not sign legal documents or be involved in work decisions.
-I will not smoke tobacco products or drink alcoholic beverages.
-I will plan to spend a few hours resting before resuming my normal routine.

I certify that I have read and understand addendum "A" regarding post-procedure limitations to my actions.
If any unforeseen condition arises during this procedure, calling for additional procedures, operations, or medication (including anesthesia and blood transfusion), I further request and authorize the above named physician to do whatever he deems advisable in my interest.

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. Missed Lesions are a possibility as studies have shown that Colonoscopy is capable of detecting 85% to 90% of polyps and other lesions that may be present. Therefore, I understand that despite an adequate exam, polyps or cancers can be missed.

Signed: _____
(By patient or person legally authorized to consent for the patient)

Witness: _____
(Center/Office Personnel Signature)

Consent to Use and Disclosure of Protected Health Information

My protected health information will be used by the Center or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. I have had the opportunity of reviewing the Notice of Privacy Practices for a more complete description of how my protected health information may be used or disclosed, and I have reviewed the notice prior to signing this consent. I understand that I may request a restriction on the use or disclosure of my protected health information. The Center may or may not agree to restrict the use or disclosure of my protected health information. If the Center agrees to my request, the restriction will be binding on the center. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The Center reserves the right to modify the privacy practices outlined in the notice. I have reviewed this consent form and give my permission to the Center to use and disclose my health information in accordance with it.

Photography Consent

I consent to the photographing and/or videos of the operation, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Observer Consent

I consent to an observer in the operation room for medical, scientific or educational purposes, provided my identity is not revealed to the observer.

Advance Directives

Upon registration, we will ask you if you have an advance directive. An advance directive is a written document, which communicates your health care wishes clearly. A copy of your advance directive must be placed in your medical record. There are two types of advance directives:
A *Durable Power of Attorney for Health Care* is a document that allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.
A *Living Will or Health Care Directive* is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make you own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

We are required to inform you of the following information prior to your procedure.

1. I have received and reviewed the policies and procedures of the Endoscopy Center of Southern California concerning the following. I have been allowed to ask questions and am satisfied with the information provided.
2. I hereby acknowledge that I have received a copy of Southern California Medical Gastroenterology Group, Inc. Notice of Privacy Practices.
3. In addition to the information provided we are required to ask if you have an Advance Directive, if yes and would like us to add that to your medical record you may do so at any time. If you need further information regarding an Advance Directive, we will provide you with further information upon your request.
   I have an Advance Directive: _____ Yes _____ No

I have received a copy of:

1. Patient Rights and Responsibilities
2. Information regarding my physician's financial interest in the Center.
3. Advance Directive Information.
4. Information on how to file a complaint or grievance.
5. Information regarding informed consent for my procedure.

Certification

The undersigned certifies that he/she has read and understood the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this agreement and consent to and accept its terms. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

Following surgery, if conscious sedation and/or general anesthesia were administered I will have a responsible person drive me home and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of conscious sedation anesthesia/general anesthesia and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgment during that period.

Written instructions have been explained and a copy has been given to me.

I have reviewed this Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of my Protected Health Information.

_____
Patient/Parent/Guardian Signature

_____
Witness: Center/Office Personnel Signature

Endoscopy Center of Southern California
2336 Santa Monica Blvd #204
Santa Monica, CA 90404

Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of Protected Health Information.

I authorize and direct my Physician to perform the following operation and/or diagnostic procedure:

COLONOSCOPY WITH POSSIBLE BIOPSY AND POSSIBLE POLYPECTOMY, POSSIBLE BANDING OF HEMORRHOIDS

and/or such other operation(s) or any other therapeutic procedure(s) which may deem necessary or advisable, including, but not limited to, the performance of services involving pathology and radiology. Upon my authorization and consent such operation or special diagnostic or therapeutic procedures will be performed for me by my physicians and surgeons and/or any other physician and surgeon or qualified persons selected by them. I understand and agree that the person(s) in attendance for the purpose of administering anesthesia or performing other specialized professional services, such as radiology, pathology, and the like, are independent contractors with me and not employees or agents of the facility or of my physician or surgeon.
I understand the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, the medically acceptable alternative procedures or treatments, and these surgical operations and special diagnostic or therapeutic procedures all may involve calculated risks or complications, injury or even death. I have a general understanding of the operation or procedure to be performed on me and that no warranty or guarantee has been made as to the result or cure.

Consent of Administration of Anesthesia

I have been informed of the following type(s) of anesthesia that may be used:___ Conscious sedation ___ Monitored Anesthesia Care/Deep Sedation

Significant risks and complications of the anesthesia to be administered have been explained and include but are not limited to: Sore throat, Nausea, Vomiting, Upper Respiratory Infection, Bronchitis, Pneumonia, Chipped Teeth, Cardiac Arrhythmia, Cardiac Arrest, and/or Respiratory Arrest. I accept these risks and hereby consent to the administration of anesthetics, No warranty or guarantee has been made as to the results thereof.

Consent to Test for Blood-Borne Diseases

I understand that it may be necessary to test my blood while I am a patient at this Center, in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example, a Center employee is stuck by a needle after giving an injection, starting an intravenous fluid, drawing blood, or sustains a scalpel injury, I understand that my blood as well as the employee's blood will be tested. I have been informed that the performance and results of the HIB antibody test are considered confidential. That the test results in my health record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who are required to keep my health record information confidential.

Consent to Resuscitation

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining (including resuscitative services). The right of self-determination may be effectuated by an advance directive.

Tissue Disposal

I hereby authorize the pathologist to use his/her discretion in the disposal of any severed tissue member or organ removed from me during the operation or procedure described above.

Consent to Transfer

I understand that the surgical and/or diagnostic procedure to be performed on me at this Center will be done on an outpatient basis and that the facility does not provide for 24-hour patient care. If my attending physician or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the facility to a hospital or other health care facility. I consent and authorize the employees of the facility to arrange for and affect the transfer.

Consent to Blood and/or Blood Products Transfusions

In the ambulatory care setting, if a patient should require a transfusion of blood and/or products, each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (include in transfusion services). The right of self-determination to refuse any transfusions of blood and/or blood products may be indicated here.
_____ **I hereby refuse to have any transfusion of blood and/or blood products**

Patient Valuables/Personal Property

I have been instructed to leave VALUABLES at home or place them in the care of family members. **I understand that the Center is not responsible for lost or damaged personal property such as glasses, contact lenses, hearing aids, dentures, jewelry, coats, and/or money.**

Payment Obligations

The patient authorizes payment of his/her insurance benefits to the Center. The patient also authorizes payment of any account owed by the patient to this Center out of insurance benefits, with any balance of said benefits to be paid to the order to the patient. The patient understands that he/she is financially responsible to the Center for charges not covered by any insurance company or any other Third Party. Patient hereby specifically agrees to pay to the Center the patient's outstanding balance at the time of discharge and in accordance with the terms and rates then in effect. The undersigned also acknowledges that they are jointly and separately liable for any and all amounts due and owing as a result of the care rendered by the Center on behalf of the patient. I/We, the undersigned agree to pay the cost of collection including a reasonable attorney's fee if this account should be placed in the hands of an Attorney for collection suit or otherwise.

PLEASE COMPLETE

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU ON THE DAY OF YOUR TEST.
THANK YOU.

OUTPATIENT HEALTH HISTORY QUESTIONNAIRE

1. GENERAL INFORMATION:

Name: (last) _____ (first) _____
Date of Procedure: _____ Type of Procedure: _____
Age: _____ Sex: _____ Height: _____ Weight: _____ lbs.

2. ALLERGIES TO MEDICATIONS OR FOODS (INCLUDING TYPE OF REACTION):

A. _____
B. _____
C. _____

3. MEDICATIONS YOU ARE TAKING (PRESCRIPTION & NON-PRESCRIPTION, INCLUDING EYE DROPS):

DRUGS / DOSAGE	DRUGS / DOSAGE
A. _____	G. _____
B. _____	H. _____
C. _____	I. _____
D. _____	J. _____
E. _____	K. _____
F. _____	L. _____

4. PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING BY PLACING A CHECK IN THE APPROPRIATE BOX:

PATIENT HISTORY	PAST SURGERY / COMMENTS
☐ GLAUCOMA	
☐ HEART DISEASE	
☐ MITRAL VALVE PROLAPSE	
☐ RHEUMATIC HEART DISEASE	
☐ PACEMAKER	
☐ HYPERTENSION	
☐ STROKE	
☐ LUNG DISEASE	
☐ VIRAL HEPATITIS	
☐ KIDNEY DISEASE	
☐ DIABETES	
☐ CANCER	
☐ PARKINSON'S DISORDER	
☐ SEIZURE DISORDER	
☐ GASTROINTESTINAL DISORDERS	
☐ BLEEDING &/OR BLOOD DISORDERS	
☐ BONE DISORDERS	
☐ PROSTHESIS / IMPLANT	
☐ PAIN	
☐ HISTORY OF ANESTHESIA PROBLEMS	
☐ ARTIFICIAL HEART VALVE	
☐ PREGNANT / LMP	

REVIEWED AND COMPLETED BY: _____

Southern California Medical Gastroenterology Group, Inc.

PLEASE COMPLETE

Southern California Medical Gastroenterology Group, Inc.
Endoscopy Center of Southern California

Patient Information Form

☐Male ☐Female E-mail: _____

Last Name_____ First Name_____ M.I._____ Date of Birth ___/___/___

Home Address_____ City _____State _____ Zip_____

Mailing Address *(if different)* _____ City _____State _____ Zip_____

Home Phone (___)_____ Work Phone (___)_____ Cell # (___)_____

Employer Name _____ Occupation _____

Address_____ City _____State _____ Zip_____

Social Security # _____ Driver's License # _____ State of Issue _____

Spouse Name _____ Work Phone #_____

Emergency Contact Name _____ Phone # (_____) _____

Referred By _____ Phone # (_____) _____

Race: (circle one)
R1 American Indian
R2 Asian
R3 Black/African American
R4 Hawaiian/Pacific Islander
R5 White
R9 Other

Ethnicity: (circle one)
E1 Hispanic/Latino
E2 Non Hispanic/Non Latino

INSURANCE INFORMATION

Primary Insurance Name _____ Phone Number (___) _____

Insured's ID Number_____ Group Number _____

Name of Insured _____ Insured's S.S. # _____-____-_____ Insured's Date of Birth ___/___/___

Secondary Insurance Name _____ Phone Number (___) _____

Insured's ID #_____ Group # _____

Name of Insured _____ Insured's S.S. # _____-____-_____ Insured's Date of Birth ___/___/___

I hereby assign to **Southern California Medical Gastroenterology Group, Inc. and/or Endoscopy Center of Southern California** all money to which I am entitled for medical and/or surgical expense relative to the service rendered by the Group. I hereby accept responsibility for payment for any medically necessary or elective service(s) provided to me that is not covered by my insurance. I understand I am financially responsible to said Group for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and /or court costs and reasonable legal fees should this be required.

I agree to pay all required copayments, coinsurance, and deductibles at the time the service is rendered in accordance with any health plan rules.

_____ _____
Signature of patient or guardian *date*

_____ _____
Witness Signature *date*