

# Digestive Disease Endoscopy Center

222 22<sup>nd</sup> Avenue North, Suite 300 | Nashville, Tennessee 37203 | (629) 255-2154  
heritagemedical.com/gastroenterology/ddec

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Dear Patient,

Enclosed is information about how to prepare for your upper endoscopy (EGD). Please read these instructions as soon as possible as some medications must be stopped a week before your procedure.

You will be sedated for this procedure, and unable to drive until the next day. You must bring a driver who can stay with you the entire time you are here and drive you home. Failure to do so will result in your procedure being rescheduled. Free wireless internet is available in our waiting room for guests to use.

We strive to stay on schedule. Our goal is to begin your procedure within one hour after the arrival time noted above. Your expected time at the endoscopy center will be 3 hours or less. Please arrive on time with completed paperwork. You will be delayed or moved to the end of the schedule if you fail to do so.

As a courtesy to other patients and to our staff, we require at least two business days notice for cancellation or rescheduling of procedures. Please see the financial policy included in this packet for more details. Call our office at (629) 255-2154 with any questions.

Expect to receive a call from a nurse one week prior to your procedure. This is to confirm your appointment and answer any questions you may have. You may also receive a survey phone call after your procedure. Please take the time to provide feedback so that we can continue to improve. We are honored by the trust you are placing in us and appreciate the opportunity to serve you.

Sincerely,  
Digestive Disease Endoscopy Center Staff

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## Preparing for your Upper Endoscopy (EGD)

- A. If you take **blood thinners** and have not spoken with a nurse at our office regarding holding this medication, please contact us as soon as possible. If you are unsure, please call and speak with a nurse in our office. A few examples of blood thinners are listed below:
- Coumadin (Warfarin), Plavix (Clopidogrel), Xarelto, Eliquis, Effient
- B. If you have an **implanted pacemaker** or **defibrillator** and have not spoken with a nurse regarding this, please notify our office.
- C. **If you are diabetic who relies on insulin**, please call the physician who manages your diabetes for advice on how to regulate your medication during your prep and on the day of your procedure.
- D. **If you take any GLP-1 medications for weight loss/diabetes**, please stop these for **two weeks** prior to your procedure. See the table below for list of GLP-1 medications.
- E. Please see the table below for which medications to stop taking before your procedure:

Medication	Stop Before Procedure
81 mg Aspirin	<b>DO NOT STOP</b>
Tylenol, acetaminophen, or Celebrex	Do not stop
325 mg Aspirin	7 Days
Iron	3 Days
Ibuprofen, Advil, Aleve, Mobic, Nuprin	2 Days
Arthritis Medications	2 Days
Alli (Weight Loss Aid)	3 Days
Phentermine	7 Days
GLP-1 medications: Mounjaro, Wegovy, Ozempic, Trulicity, Victoza, Rybelsus, Byetta, Bydureon	14 Days

- F. Continue using any prescribed inhalers and **bring them with you to your appointment**.

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## THE DAY BEFORE YOUR EGD

- Eat and drink normal during the day
- Eat a **light** meal for dinner (avoid having a large, fatty meal)
- Nothing to eat or drink after midnight

## THE DAY OF YOUR EGD

- **Do not eat or drink anything after midnight.** Do not use chewing tobacco or smokeless tobacco of any kind on the morning of your procedure. Failure to comply with these directions will result in delay or cancellation of your procedure.
- Take your necessary medications at least two hours prior to the procedure with only enough water to swallow the pills.
- Wear comfortable clothes that are easy to put back on and wear socks to keep your feet warm. Do not wear jewelry, apply lotion to the chest area, or wear contact lenses unless you can sleep in them.

## Please bring the following to your appointment:

- An updated list of medications and dosages (or bring your medications with you)
- A responsible adult who must **stay in the waiting room and drive you home**
  - You must not operate a motor vehicle until the following day.
  - We cannot start preparing you for your procedure unless your driver is present.
  - This person will help you remember what the doctor tells you about the results.
- Two forms of ID *or* one photo ID (driver's license, passport, etc.)
- Your insurance cards
- **Fully completed** forms that are included in this packet

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## Heritage Medical Downtown Building

222 22<sup>nd</sup> Ave North, Suite 300

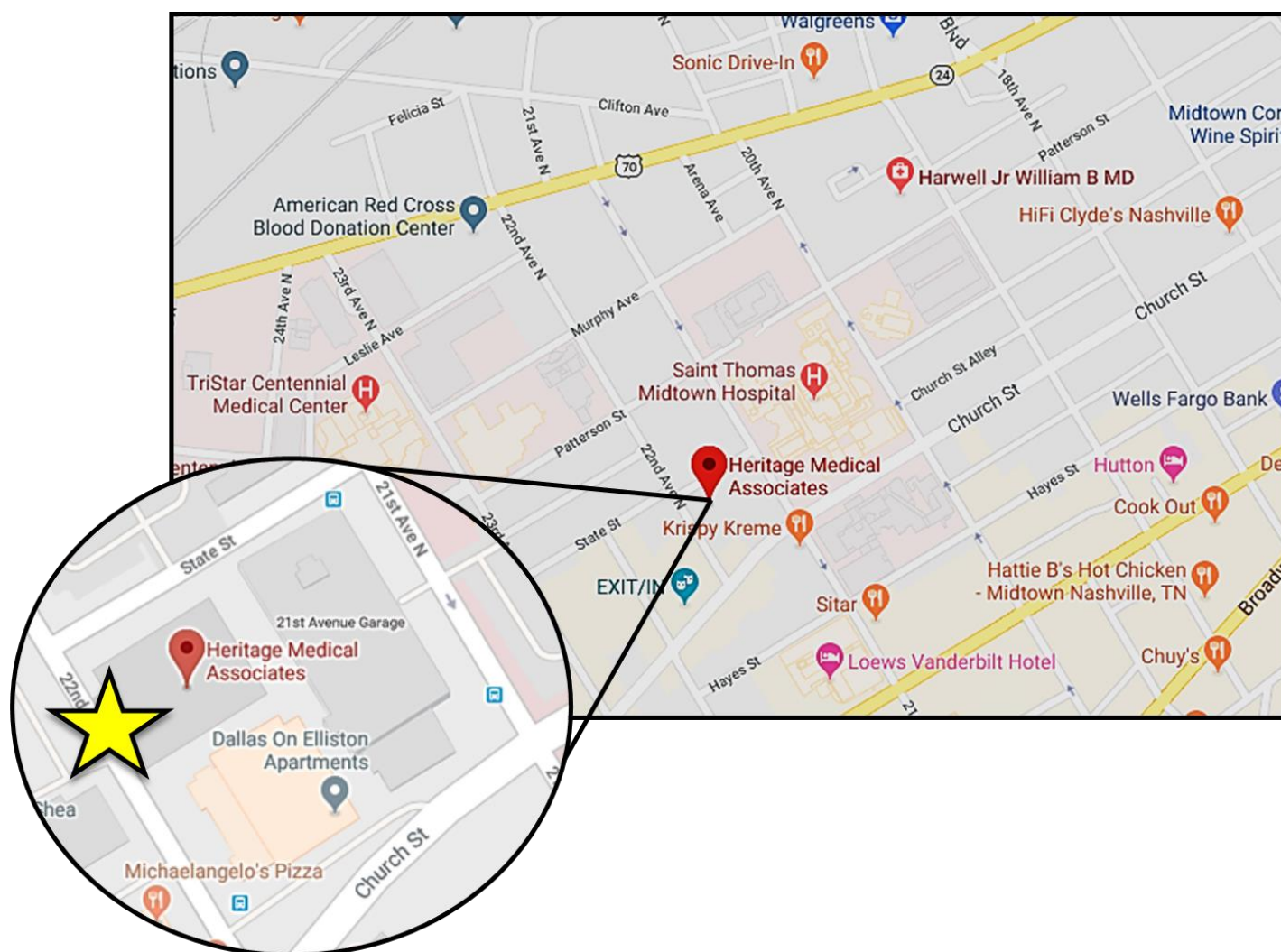
Nashville, TN 37203

Main entrance is on 22<sup>nd</sup> Ave N (★).

Drive straight past the front door and turn right into the parking garage (parking is free).

We are located on the third floor of the building.

**\*If arriving before 7:00 AM, the front entrance to the building is locked. To enter, take the crosswalk located on the 3<sup>rd</sup> floor of the parking garage. The doors of the crosswalk are open at 5:45 AM.\***



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## 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.

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

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**Ownership Disclosure:** The following physicians are owners of the Endoscopy Center: David McMillen, MD, Joseph Parker, MD, and Ryan Roberts, 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 629-255-3880.

**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 629-255-3514.

-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 3 business days** 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 \_\_\_\_\_

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## DEMOGRAPHICS SHEET

Patient Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_  
SSN \_\_\_\_\_ Employer \_\_\_\_\_

### Patient Contact Information

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

**Appointment Reminder Preference**      ☐ Call      ☐ Text      ☐ Email

### 1<sup>st</sup> Insurance Coverage

Subscriber Name \_\_\_\_\_ Insurance Carrier \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name \_\_\_\_\_

### 2<sup>nd</sup> Insurance Coverage

Subscriber Name \_\_\_\_\_ Insurance Carrier \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_ Group Name \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

<b>Marital Status:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Employment Status:</b>	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Not employed	<input type="checkbox"/> Self Employed
	<input type="checkbox"/> Retired	<input type="checkbox"/> Military		
<b>Student Status:</b>	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Not a student	
<b>Race:</b>	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> African American
	<input type="checkbox"/> Native American	<input type="checkbox"/> White	<input type="checkbox"/> More than One Race	<input type="checkbox"/> Declined to Answer
<b>Ethnicity:</b>	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Declined to Answer	
<b>Preferred Language:</b>	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other _____	

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Please answer all questions, as this will become part of your medical history.

Patient Name \_\_\_\_\_ Appt Date \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Age \_\_\_\_\_

**Drug Allergies** ☐ No Known Drug Allergies

Drug	Reaction	Drug	Reaction

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...) \_\_\_\_\_

\_\_\_\_\_

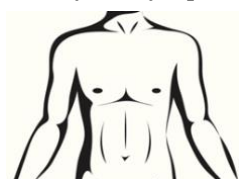
What helps relieve your symptoms? (e.g. eating, bowel movements, specific positions, relaxation, medicines...) \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Please indicate on the diagram where your symptoms are located:



Physician Use Only



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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? \_\_\_\_\_

What medicines or treatments have you tried and did they help? \_\_\_\_\_

Please list all your other current medical problems and diagnoses. \_\_\_\_\_

Please list your current medications, dosages, and how often you take them. If you prefer, provide a list of your medications, or bring them with you to your appointment.

Drug	Strength	How Often

Drug	Strength	How Often

Pharmacy Name \_\_\_\_\_ Zip Code \_\_\_\_\_

## Past Medical History

Surgical Operations and Hospitalizations \_\_\_\_\_

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

Have you had colon polyps in the past? ☐ Yes ☐ No

Have you had colon cancer? ☐ Yes ☐ No

Have you ever had an upper endoscopy (EGD)? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

Have you ever had an ulcer? ☐ Yes ☐ No

Have you ever been given a blood transfusion? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

Have you ever been diagnosed with:

☐ Hepatitis ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Pancreatitis ☐ Barrett's Esophagus

Do you have a pacemaker/defibrillator? ☐ Yes ☐ No If yes, who placed it? \_\_\_\_\_

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## 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 \_\_\_\_\_ At what age? \_\_\_\_\_
- ☐ Crohn's Disease      Family Member \_\_\_\_\_ At what age? \_\_\_\_\_
- ☐ Liver Disease/Cirrhosis      Family Member \_\_\_\_\_ At what age? \_\_\_\_\_
- ☐ Pancreatic Cancer/Pancreatitis      Family Member \_\_\_\_\_ At what age? \_\_\_\_\_
- ☐ Other Diseases in Family \_\_\_\_\_

## Social History

Marital Status      ☐ Single      ☐ In long term relationship      ☐ Married      ☐ Divorced      ☐ Widowed

Any children?      ☐ Yes      ☐ No      If yes, how many? \_\_\_\_\_

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      If yes, how many drinks/day? \_\_\_\_\_

Are you an Organ Donor?      ☐ Yes      ☐ No

## Review of Systems

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fever                      | <input type="checkbox"/> Constipation             | <u>Neurological</u>                                  |
| <input type="checkbox"/> Weight Gain (Amount _____) | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Weight Loss (Amount _____) | <input type="checkbox"/> Difficulty Swallowing    | <input type="checkbox"/> Stroke                      |
| <u>Cardiovascular</u>                               | <input type="checkbox"/> Indigestion              | <u>Psychiatric</u>                                   |
| <input type="checkbox"/> Chest pain                 | <input type="checkbox"/> Jaundice (Yellow Skin)   | <input type="checkbox"/> Feeling of Depression       |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Nausea/Vomiting          | <input type="checkbox"/> Substance Abuse/Dependence  |
| <u>Endocrine</u>                                    | <input type="checkbox"/> Reflux                   | <u>Respiratory</u>                                   |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Vomiting Blood           | <input type="checkbox"/> Cough                       |
| <input type="checkbox"/> Thyroid Problems           | <u>Hematology</u>                                 | <input type="checkbox"/> Wheezing                    |
| <u>Gastroenterology</u>                             | <input type="checkbox"/> Anemia/Low Blood Counts  | <input type="checkbox"/> Shortness of Breath         |
| <input type="checkbox"/> Abdominal Pain             | <input type="checkbox"/> Easy Bleeding/Hemophilia | <u>Urinary Tract</u>                                 |
| <input type="checkbox"/> Black, Tarry Stool         | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Dark Urine                  |
| <input type="checkbox"/> Bloody Stool               | <u>Musculoskeletal</u>                            | <input type="checkbox"/> Difficult/Painful Urination |
| <input type="checkbox"/> Change in Bowel Habits     | <input type="checkbox"/> Joint Pain               | <input type="checkbox"/> Kidney Stones               |

## PHYSICIAN USE ONLY

Review of Symptoms	Normal	Abnormal	Comments
Heart, rate and rhythm			
Respiratory			
Gastrointestinal			

Physician signature \_\_\_\_\_

Date \_\_\_\_\_