NORTHERN COLORADO
ENDOSCOPY
CENTER

8227 W 20th Street
Greeley, CO 80634
Ph: (970) 573-7555
F: (970) 744-5309

Personal History Packet

Please read this entire packet
Fill out **all** paperwork in its entirety:

- Tell us about yourself
- Medication – if you have a list already made, please attach a copy to this form
- Consent form

Please bring the above forms with you to the appointment.

*We are not part of UCHealth or Banner

*We do not have access to outside medical records

Centers for Gastroenterology
Specialists in Digestive Health

COLONOSCOPY PREP – Golytely/Colyte/Nulytely

Please read the following instructions carefully at least 7 days before your scheduled procedure.

It is absolutely necessary that you complete the following instructions, <u>with no changes</u>, unless specified by your physician.

TIMELINE	What YOU Need to Do	Comments
7 days before procedure	▪ **Avoid ALL Nuts, seeds, corn, and RAW green vegetables** ▪ Arrange for a responsible adult to drive you to the facility on the day of your procedure ▪ **<u>IF YOU TAKE BLOOD THINNER PRODUCTS</u>**: Follow the instructions for your blood thinner products as you were directed by your GI physician, cardiologist, or prescribing physician. ▪ **<u>IF YOU TAKE INSULIN PRODUCTS OR ORAL DIABETES PILLS</u>**: Contact your physician to obtain specific directions for dosages on the day before and day of your procedure.	**You will need a responsible adult to drive you home from the procedure. It is the facilities policy to cancel the procedure if you do not have a ride home.**
5 days before procedure (or as soon as it is ordered go and get your prep and Dulcolax)	▪ Go to the pharmacy and pick up the following: ☒ Your prescribed Golytely/Colyte/Nulytely Kit ☒ ****1 box with at least 2** Bisacodyl (Dulcolax) **laxative tablets (do not use stool softeners) you will find this over the counter in the laxative aisle**	**You will find this over the counter in the laxative aisle, it is <u>NOT</u> a prescription.**
1 day before procedure	▪ **BREAKFAST:** You may have a **light** breakfast. **<u>This MUST be completed by 9AM.</u>** ▪ Choose from **<u>ONE</u>** of the following: ○ White bread/toast **<u>OR</u>** ○ Rice cereal **<u>OR</u>** ○ Cream of wheat **<u>OR</u>** ○ Eggs **You may also have the following:** ○ Milk ○ Juice (no red, blue, or purple) ▪ **After 9am and until AFTER YOUR PROCEDURE, do not eat anything and drink only clear liquids** (no red, blue, or purple). Clear liquids include: ▪ Water & Tea ▪ Plain coffee, no creamer or milk ▪ Clear juices such as apple or white grape juice ▪ Lemonade from powdered mix ▪ Kool Aid or Crystal Light ▪ Clear Soda (7-Up, Sprite, Ginger Ale) ▪ Gatorade/PowerAde ▪ Fat free broth/ bouillon/ consommé ▪ Plain/flavored gelatins **(no fruit added)** ▪ Italian ices, sorbet, popsicles	▪ BREAKFAST MUST BE COMPLETED BY 9AM ▪ CLEAR LIQUIDS ONLY AFTER 9AM **SEE REVERSE FOR ADDITIONAL INSTRUCTIONS**

Centers for Gastroenterology
Specialists in Digestive Health

COLONOSCOPY PREP – Golytely/Colyte/Nulytely

TIMELINE	What YOU Need to Do	Comments
1 day before your procedure at **12:00PM**	☒ **Take 2 Bisacodyl (Dulcolax) laxative tablets.**	***You will find this over the counter in the laxative aisle, it is NOT a prescription.**
1 day before your procedure at **5:00PM**	▪ **Mix the Colyte/GoLytely/NuLytely with 1 gallon (4 liters) of water in the container provided.** ▪ **Shake or mix well.** ▪ You may chill the solution but do not ice it. To improve the taste, you can add Crystal Light (not red or purple colored) to the prep ▪ Continue with clear liquids for the rest of the evening	Stay close to restroom. You may use baby wipes or A&D ointment to alleviate discomfort from your prep results.
1 day before your procedure at **6:00PM**	**1. Begin drinking the prep solution.** **2. Drink 8 ounces (1 cup) every 10-15 minutes until you have drunk 12 cups. This is ¾ of the gallon container.** **3. Save 4 cups (or ¼ of the container) for the next morning**. **4**. Continue drinking clear liquids for the rest of the evening	
DAY OF PROCEDURE: **FIVE hours prior before check-in time** (For example, if you are to check-in at 7:15am, you will need to get up at 2:15am and drink the rest of the liquid in the gallon container.)	▪ You may take your medications as instructed (especially heart and blood pressure) up to 4 hours prior to checking in for your procedure. ▪ **Begin drinking the remaining prep solution.** ▪ **Drink 8 ounces (1 cup) every 10-15 minutes until you have finished the remainder of the gallon container.** ▪ Follow specific directions given by your physician regarding insulin, oral diabetic pills, and blood thinners. ▪ **After that, stop all fluids.** ▪ **Nothing by mouth, including gum, mints, and candy starting 4 hours prior to your procedure until after your procedure is complete.**	**DO NOT take any medications after completing your 2nd dose of prep.** Your bowel movements will turn watery and -toward the end of the prep-will appear yellow or clear. If the bowel movement is NOT YELLOW OR CLEAR, notify the pre-op nurse when you arrive at the facility.
Appointment time	▪ Arrive at your appointment check-in time with your responsible adult driver (see page 1).	**For your safety, your procedure will be cancelled if you do not have a ride home arranged.**

VIDEO INSTRUCTIONS ALSO AVAILABLE WITH QR CODE

Open the camera on your cell phone and center the viewfinder over the QR code. Tap on the notification that appears in the viewfinder of the camera to be directed to the video instructions.

ABOUT YOUR COLONOSCOPY

Dear Patient:

Your physician has referred you for a colonoscopy. The purpose of this letter is to familiarize you with the nature of the exam, its benefits and its risks. What follows is absolutely essential for you to know, so please read this carefully. We consider your understanding of this material to be so important that we will ask you to sign this letter acknowledging you have read and understood this information. If you have any questions please contact us by phone (970-573-7555) before the procedure so we can discuss your concerns with you.

Why you should have a colonoscopy: Colonoscopy is an examination of the entire colon (large intestine) using a long, thin, flexible tube with a television camera on the tip called a colonoscope. The procedure is done for a number of different purposes. The most common goal is an effort to prevent colon cancer. Without any screening, about one out of twenty people will develop colon cancer. The risk is even higher for people with a family history of colon cancer. Most, but not all, cancers begin as benign tumors called colon polyps. Over time polyps can grow and become cancers. Finding and removing colon polyps markedly reduces your risk of developing colon cancer. Likewise, if a colonoscopy is done, and no colon polyps are found, it is unlikely that you will have problems with colon cancer within the next 5 years. Other reasons for having a colonoscopy include searching for a cause for diarrhea, abdominal pain, blood in the stools, and anemia.

The procedure: The preparation for the examination starts with a laxative, which is described in detail in the prep instructions. Good visualization of the colon depends on an adequate colon cleansing.

The actual examination usually takes between 15 and 30 minutes. Before the procedure an IV will be started in order to give necessary medications. Heart and lung function monitors are used to enhance safety. You will lie in a comfortable position in a bed. To prevent cramping and pain during the procedure you are sedated. The setting is calm and private. Because of the medications, you will probably remember little or none of the procedure. It is unlikely that you will find the examination to be unpleasant. Most people feel that the only unpleasant part of the entire process is the laxative, but as noted above, it is vital to the success of the procedure.

After the procedure, it will take you about a half an hour to wake up enough to leave the endoscopy center. Most people are in and out of the endoscopy center in about two hours. Because of the sedation, you will need a ride home. You will not be able to drive for at least 12 hours. You will probably be able to resume most of your normal activities about six hours after the procedure. If polyps are removed, there is a small risk of bleeding for up to two weeks afterwards. For this reason, you should only have the procedure done if you will be within easy reach of an emergency room for the next 14 days.

Examples of activities you need to avoid for two weeks after polyps are removed include travel in airplanes and backcountry recreation. It is fine to drive to areas with reasonable levels of emergency medical care.

The Limitations of Colonoscopy: Colonoscopy is the most effective cancer preventative test we have, but it is not perfect. Having a colonoscopy can be expected to decrease your risk of dying from colon cancer by about 90 percent over the next five to ten years. Unfortunately, cancers can still develop, although very rarely, in this interval after a colonoscopy. This occurs for two main reasons. First of all, polyps can be missed during a colonoscopy. In the best of circumstances, this seems to happen to about 10 percent of polyps. This problem is due to difficulty in seeing the entire colon because of the presence of sharp folds and corners, poor cleansing of the colon, and limitations in the view of the TV camera. These factors can all create "blind spots". The second cause for the appearance of cancers within several years of a colonoscopy is that some cancers simply seem to develop extremely rapidly. While not perfect, colonoscopy is still extremely worthwhile since it can be expected to prevent the vast majority of deaths that would otherwise occur from colon cancer. At this time, colonoscopy is the most effective screening tool for colon cancer.

Alternatives to Colonoscopy: Other screening tests for colon cancer include testing the stool for occult (invisible) blood, Cologuard, a limited scope exam without sedation called a flexible sigmoidoscopy, and barium enema X-ray. All of these have been shown to prevent some cases of colon cancer, but they are far less reliable than a colonoscopy. Furthermore, if they do detect a problem, in all cases you will need a colonoscopy to confirm the result. While they are better than doing nothing, these three alternative screening methods are clearly inferior to colonoscopy for protecting your health. CT and MRI scanning colon exams are available, but are still in development. At this time they are of uncertain benefit. In addition, these procedure may require the same prep and are often not covered by insurance. Furthermore, if polyps are found, a follow-up colonoscopy will be required to remove them.

The Risks of Colonoscopy: Like all invasive medical procedures, colonoscopy has a chance of causing complications. Fortunately, the odds of a complication are very low. Two serious problems that are rarely encountered are perforation (poking a hole) of the colon and severe bleeding. These events can be life- threatening. Treating either of these complications might require surgery and blood transfusions. The risk of either of these events is much less than one percent. They occur somewhere between 1 in 500 to 1 in 1000 colonoscopies. Less common problems are severe medication reactions or heart attacks. Localized irritation of the vein (phlebitis) may occur at the site of medication injection. While these complications do rarely occur, it must be remembered that the risk of dying from colon cancer is far higher than the risk of suffering a complication from the examination. Your safety is our foremost concern, and the entire process is designed to minimize your chances of injury.

Please contact us at 970-573-7555, if you would like to discuss any of this further. You will, of course, have an opportunity to speak to us immediately before the procedure.

Drs. Strong, North, Sears, Langer, Caufield, Dunphy, Durkan, Jenkins, Kershner, Hampton, Huerta, Webb and Settergren have a financial ownership in Northern Colorado Endoscopy Center.

Sincerely Yours,

Centers for Gastroenterology Physicians

By signing here, you certify that you have read and understood the information pertaining to the Colonoscopy. If you have questions, please do not sign this until we have answered them for you.

Signature____ Date________________________

Name____ Date of Birth _________________

8227 W. 20Th STREET
GREELEY, CO 80634

P. (970) 573-7555
WWW.NOCOENDOSCOPY.COM

ABOUT YOUR UPPER ENDOSCOPY

Dear Patient:

Your physician has referred you for an exam of your upper digestive tract, which is called an upper endoscopy or an EGD. Sometimes it is called a gastroscopy. The purpose of this letter is to familiarize you with the nature of the exam, its benefits and its risks. What follows is absolutely essential for you to know, so please read this carefully. We consider your understanding of this material to be so important that we will ask you to sign this letter acknowledging you have read and understand this information. If you have any questions, please contact us by phone (970-573-7555) before the procedure so we can discuss your concerns with you.

What is an EGD?

An EGD is a test done with an endoscope, which is a long, flexible tube that is thinner than most food you swallow. After you are sedated, the tube is passed through the mouth into the upper digestive tract. As a result of the sedation, you are unlikely to gag, feel discomfort, or remember the procedure. The test allows physicians to examine the lining of the esophagus, stomach and duodenum (the first portion of the small intestine).

If the doctor sees a suspicious area, he/she can take a small piece of tissue (a biopsy) for examination in the laboratory. Biopsies are taken for many reasons and do not necessarily imply cancer. The physician can also remove polyps and abnormal tissue during the exam. If a narrowing of the esophagus (also called a stricture) is causing difficulty swallowing, the doctor might stretch the narrow spot. This is called an esophageal dilation.

The actual examination usually takes about 15 minutes. Before the procedure, an IV will be started in order to administer the necessary medications. Heart and lung function monitors are used to enhance safety. You will lie in a comfortable position in a bed. Because of the medications, you are likely to remember little to none of the procedure. It is unlikely you will find the examination to be unpleasant. After the procedure, it will take you about half an hour to wake up enough to go home. Most people are in and out of the endoscopy center in about two hours. Because of the sedation, you will need a ride home. You will not be able to drive for at least 12 hours. You will probably be able to resume most of your normal activities about six hours after the procedure.

Why is an EGD necessary?

Many problems of the upper digestive tract cannot be as accurately diagnosed by x-ray. An EGD may be helpful in the diagnosis of inflammation of the esophagus, stomach and duodenum (esophagitis, gastritis, duodenitis), hiatal hernia, and to identify the site of upper gastrointestinal bleeding.

An EGD is more accurate than x-ray in detecting gastric (stomach) and duodenal ulcers, especially when there is bleeding or scarring from a previous ulcer. An EGD may detect early cancers too small to be seen by x-ray and can confirm the diagnosis by biopsies and brushings. Nonetheless, an EGD is not 100% accurate in some cases.

Alternatives to an EGD?

Although an upper endoscopy (EGD) provides a more accurate assessment of the esophagus, stomach and duodenum, certain situations may favor x-ray examination of the stomach. In some circumstances, ultrasound tests, CT scans or even surgery can be considered as alternative studies.

Are there any complications from an EGD?

An EGD is safe with very low risk when performed by physicians who have been trained and are experienced in this endoscopic procedure. Two serious problems that are rarely encountered are perforation (poking a hole) of the intestinal tract and severe bleeding. These events can be life threatening. Treating either of these complications might require surgery and blood transfusions. The risk of either of these events is much less than one percent. Bleeding may occur from the site of biopsy or polyp removal. It is usually minimal, but rarely may require transfusions or surgery. Localized irritation of the vein (phlebitis) may occur at the site of medication injection. Other risks include drug reactions and complications from unrelated diseases such as heart attack or stroke.

In Summary:

An EGD is an extremely worthwhile procedure that is very well tolerated and is invaluable in the diagnosis and proper management of disorders of the upper digestive tract. The decision to perform this procedure is based upon assessment of you particular problem. If you have any questions about your need for an EGD, do not hesitate to speak to the doctor. Both of you share a common goal—your good health – and it can only be achieved through mutual trust, respect and understanding.

Please contact us at 970-573-7555 if you would like to discuss any of this further. You will, of course, have an opportunity to speak to us immediately before the procedure.

Drs. Strong, North, Sears, Langer, Caufield, Dunphy, Durkan, Jenkins, Kershner, Hampton, Huerta, Webb and Settergren have a financial ownership in Northern Colorado Endoscopy Center.

Sincerely Yours,

Centers for Gastroenterology Physicians

By signing here, you certify that you have read and understood the information pertaining to the EGD (Upper Endoscopy). If you have questions, please do not sign this until we have answered them for you.

Signature____ Date______________________

Name____ Date of Birth ________________

TELL US ABOUT YOURSELF

Please complete this form and bring it and this packet to your procedure.

Why are you having this procedure? ______________________________

Do you take blood thinning medication? ❑ Yes ❑ No ***Are you, or could you be, pregnant?*** ❑ Yes ❑ No

Do you use oxygen at home? ❑ Yes ❑ No ***Amount of oxygen used*** ______________

Do you smoke or use tobacco products? ❑ Yes ❑ No ***Amount/Frequency*** ______________

Do you drink alcohol? ❑ Yes ❑ No ***Amount/Frequency*** ______________

Do you use marijuana products? ❑ Yes ❑ No ***Amount/Frequency*** ______________

Do you currently have any of the following medical conditions or history of? If yes, please briefly explain.

❑ Yes ❑ No Diabetes ______________________________
❑ Yes ❑ No High Blood Pressure ______________________________
❑ Yes ❑ No Heart Disease ______________________________
❑ Yes ❑ No Asthma/COPD ______________________________
❑ Yes ❑ No Stroke ______________________________
❑ Yes ❑ No Liver Problems ______________________________
❑ Yes ❑ No Blood Clots ______________________________
❑ Yes ❑ No Kidney Problems ______________________________
❑ Yes ❑ No Sleep Apnea ______________________________
❑ Yes ❑ No Other ______________________________

Previous Surgeries:

Surgery/Approximate Date: ______________________________

Surgery/Approximate Date: ______________________________

Please list any of your blood relatives with a history of colon cancer or colon polyps (relation and age):

____

Previous Endoscopic Procedure Findings:

Colonoscopy ______________ Approximate Date: ______________

Upper Endoscopy ______________ Approximate Date: ______________

Do you have a living will? ❑ Yes ❑ No ***Do you have a medical durable power of attorney?*** ❑ Yes ❑ No

Do you want any information regarding these? ❑ Yes ❑ No

______________________________ ______________________________

Signature ***Date***

Please complete medication form on back page.

8227 W. 20Th STREET
GREELEY, CO 80634

P. (970) 573-7555
WWW.NOCOENDOSCOPY.COM

PATIENT MEDICATION FORM

Allergies or sensitivities to medications or substances (including food, latex, etc.) AND reactions OR ☐ **No Known Allergies**

Medication or Substance	**Reaction (i.e. hives, difficulty breathing)**

Home Medications on Admission (Prescriptions, OTC, Herbs, Vitamins, Supplements, Patches, Inhalers, Etc.) **PLEASE NOTE – WE DO NOT HAVE ACCESS TO OUTSIDE HEALTH RECORDS – YOU MUST FILL THIS OUT OR ATTACH A LIST**				
Medication and Route	Reason for taking	Dose	Frequency	Last Taken
Verified medication/allergy list with patient pre-procedure: (RN initials) ______________________				

Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. Medication prescribed as a result of your visit has been noted below as well. Your signature below means that you understand these instructions.

DO NOT COMPLETE ANYTHING BELOW THE LINE. THIS IS FOR CLINIC STAFF ONLY.

New Medications / Previous Medications with changes					
Medication / Reason	Dose	Route	Frequency	Indications/Instructions	Last Dose

Medications given on date of procedure:

Pre-procedure:
- ☐ No medications
- ☐ Zofran for Nausea
- ☐ Other medications: ________________________________

After procedure:
- ☐ No medications
- ☐ Zofran for Nausea
- ☐ Other medications: ________________________________

During procedure:
- ☐ No medications
- ☐ Propofol for sedation
- ☐ Fentanyl for sedation or discomfort
- ☐ Versed for sedation
- ☐ Zofran for nausea
- ☐ Other Medications: ________________________________
  ____

Patient/Responsible Party Signature ____

Reviewed and copy sent with patient/responsible party: Date___________________ **RN Initials** _____________________

COLONOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE

Patient: ____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr.__________________ to perform procedure: **Colonoscopy with possible biopsy and/or polypectomy.**

I understand the reason and BENEFITS for the procedure are: **Examination of the colon with possible removal of tissue and/or removal of a polyp for diagnosis.**

Alternatives include: x-rays, Cologuard, Fecal Occult Blood Test or do nothing.

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, aspiration pneumonia and missed lesions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure includes: **BLEEDING OR PERFORATION. IF EITHER OF THESE COMPLICATIONS OCCUR, TREATMENT MAY INCLUDE HOSPITALIZATION, SURGERY OR BLOOD TRANSFUSION.**

3. SEDATION AND ANESTHESIA: The administration of sedation and anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such sedatives or anesthetics as may be considered necessary by the person responsible for these services.

4. RESUSCITATION: I desire all resuscitative measures be employed during the procedure.

5. ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize the physician to perform such treatment as deemed necessary to improve health.

6. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

7. I consent to the photographing of the procedure to be performed for medical purposes.

8. I consent to the admittance of medical or paramedical observers to the procedure room.

9. I hereby request and authorize this health care facility to preserve for scientific or teaching purposes or otherwise dispose of the removed tissue resulting from the procedures authorized above. I further authorize the pathologist, whose services may be required, to use discretion in the disposal.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN, YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM.

UPPER ENDOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE

Patient: ____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr.__________________ to perform procedure: **Esophagogastroduodenscopy (Upper Endoscopy, EGD) with possible biopsy, esophageal or gastric outlet dilation).**

I understand the reason for the procedure is: **Examination of the esophagus, stomach and duodenum with possible removal of tissue for diagnosis. There may also be possible dilation of a stricture of the esophagus or gastric outlet.**

Alternatives include: x-rays or do nothing.

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, aspiration pneumonia and missed lesions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure includes: **BLEEDING OR PERFORATION. IF EITHER OF THESE COMPLICATIONS OCCUR, TREATMENT MAY INCLUDE HOSPITALIZATION, SURGERY OR BLOOD TRANSFUSION.**

3. SEDATION AND ANESTHESIA: The administration of sedation and anesthesia also involves risks, mostimportantly a rare risk of reaction to medications causing death. I consent to the use of such sedatives or anesthetics as may be considered necessary by the person responsible for these services.

4. RESUSCITATION: I desire all resuscitative measures be employed during the procedure.

5. ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize the physician to perform such treatment as deemed necessary to improve health.

6. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

7. I consent to the photographing of the procedure to be performed for medical purposes.

8. I consent to the admittance of medical or paramedical observers to the procedure room.

9. I hereby request and authorize this health care facility to preserve for scientific or teaching purposes or otherwise dispose of the removed tissue resulting from the procedures authorized above. I further authorize the pathologist, whose services may be required, to use discretion in the disposal.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN, YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM.

WHAT TO EXPECT AFTER YOUR COLONOSCOPY

Dear Patient:

Please follow these guidelines to ensure the best possible outcome after your procedure:

- Do not drive, operate hazardous machinery, or make critical legal decisions for at least 12 hours.
- You should be in the presence of an adult for 4-6 hours after your procedure.
- Resume medications when you start eating, unless otherwise instructed.
- Mild bloating is normal. Discomfort can be relieved by walking or lying on your stomach.
- If a polyp is removed, you must remain in this area or an area easily accessible to emergency health care for 14 days.
- If biopsies are taken you will be contacted with results within 1-2 weeks.
- You may have a small amount of blood on the toilet paper or in the stool after bowel movements. If you pass large amounts of blood or blood clots, call us at 970-573-7555 immediately, and at any time of day or night, or go to the nearest emergency department.
- You should call us at 970-378-1414 immediately, and at any time of day or night, if you have a fever or persistent abdominal, back or chest pains, shortness of breath, or any concerns.

8227 W. 20Th STREET
GREELEY, CO 80634

P. (970) 573-7555
WWW.NOCOENDOSCOPY.COM

WHAT TO EXPECT AFTER YOUR UPPER ENDOSCOPY

Dear Patient:

Please follow these guidelines to ensure the best possible outcome after your procedure:

- Do not drive, operate hazardous machinery, or make critical legal decisions for at least 12 hours.
- You should be in the presence of an adult for 4-6 hours after your procedure.
- Resume medications when you start eating, unless otherwise instructed.
- Mild bloating is normal. Discomfort can be relieved by walking.
- You may have a slightly sore throat which could last 1-2 days. Use warm salt-water gargles or lozenges.
- If biopsies are taken you will be contacted with results within 1-2 weeks.
- You should call us at 970-378-1414 immediately, and at any time of day or night, if you have a fever, severe throat or neck pain or persistent abdominal, back or chest pains, shortness of breath, or any concerns.

NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

Decision Making

You or your representative have the right to:

- Be informed before care is given or discontinued whenever possible.
- Receive accurate and current information regarding your health status in terms you can understand.
- Participate in planning for your treatment, care and discharge recommendations.
- Receive an explanation of proposed procedures or treatments, including risks, serious side effects and treatment alternatives, including request for second opinion.
- Participate in managing your pain effectively.
- Receive emergency care or transfer to a higher level of care (hospital), if necessary, with a full explanation of your medical need for transfer. No wait for insurance authorization will be required and no financial penalty will be imposed.
- Have persons of your choice promptly notified of hospital admission.
- Accept, refuse or discontinue a treatment or drug, to the extent permitted by law, and be informed of the consequences of such refusal.
- Accept, refuse or withdraw from clinical research.
- Accept, refuse or withdraw from diagnostic or therapeutic procedures.
- Choose or change your healthcare provider.

Equality of Care

You have the right to:

- Respectful treatment, which recognizes and maintains your dignity and personal values without discrimination on the basis of race, color, national origin, sex, age or disability.
- Accurate information about the facility where services are received and the name, credentials and job function of health care personnel involved in your care.
- Interpreters and/or special equipment to assist with language needs.
- Information on how to obtain auxiliary aids or services should these be required.
- Information about continuing healthcare requirements following discharge, including how to access care after hours.

Confidentiality and Privacy

You have the right to:

- Personal privacy and care in a safe setting free from abuse, harassment, discrimination or reprisal.
- Sharing of personal information only among those who are involved in your care.
- Confidentiality of your medical and billing records.
- Notification of privacy practices.
- Notification of breach of unsecured personal health information.

Grievance Process

You, or your representative, have the right to:

- Fair and objective review of any complaint you have regarding care received from healthcare providers/personnel, without fear of reprisal.
- Submit a formal complaint either verbally or in writing as shown below. You will receive a written notice of decision within 15 business days from the date the complaint was made known to the Center.

Administrator of ASC serving as Compliance Officer: 970-573-7555

Colorado Department of Health: 303-692-2904 or email: hfdintake@cdphe.state.co.us

Department of Registry Agency: 303-894-7800 or http://www.dora.state.co.us/medical/complaints.html

CMS Ombudsman: 1-800-MEDICARE (1-800-633-4227) or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Office of Inspector General: 800-447-8477 or https://www.oig.hhs.gov/hotlineoperations, or US Department of Health & Human Services, Attn: OIG Hotline Operations, P.O.BOX 23489, Washington D.C. 20026

Office of Civil Rights: https://www2.ed.gov/about/offices/list/ocr/docs/howto.html

Advance Directives

You have the right to know that:

- You may provide a Living Will and/or Medical Power of Attorney.
- It is Northern Colorado Endoscopy Center's policy, regardless of the contents of any advance directive or instructions from a healthcare surrogate, that if a life threatening condition should occur during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you via ambulance to an acute care hospital for further evaluation.

Access to Medical Records

You have the right to:

- Speak privately with health care providers knowing that your health care information is secure.
- Review and/or receive a copy of your Medical Records (including electronic format), within 30 days by secure transmission, upon written request.

Seclusion and Restraints

You have the right to:

- Be free from seclusion or restraint for behavioral management unless medically necessary to protect your physical safety or the safety of others.

Billing

You have the right to:

- Information specific to fees for services and payment policies, prior to the date of service.
- Payment privacy when you choose to opt out of insurance coverage, in accordance with federal regulations.

PATIENT RESPONSIBILITIES

Providing Information

You have the responsibility to:

- Provide accurate and complete information about present problems, past illnesses, hospitalizations, current use of prescribed or OTC medications, current use of nutritional supplemental products, and other health-related matters.
- Report perceived risks in your care and unexpected changes in your condition.
- Provide an Advance Directive, if you have one.
- Provide accurate and updated demographic and contact information for insurance and billing.

Involvement

You have the responsibility to:

- Participate in your plan of care and follow the recommended treatment plan.
- Ensure you have a designated responsible adult to provide transportation and assist with your care for 4-6 hours after your procedure.

Respect and Consideration

You have the responsibility to:

- Act in a respectful and considerate manner toward healthcare providers, other patients, and visitors; physical or verbal threats or conduct, which are disruptive to business operations, will not be tolerated.
- Be respectful of the possessions or property of others, as well as the facility property.
- Assist in keeping noise levels and the number of visitors to a minimum.

Insurance Billing

You have the responsibility to:

- Know the extent of your insurance coverage.
- Know your insurance requirements including pre-authorization, deductibles and co-payments. Deductible amounts owed and copayments are expected at time of service.
- Call the billing office with questions or concerns regarding your bill.
- Fulfill your financial obligations as promptly as possible.

Your physician may have a financial ownership stake in Northern Colorado Endoscopy Center.

8227 W. 20Th STREET
GREELEY, CO 80634

P. (970) 573-7555
WWW.NOCOENDOSCOPY.COM

Northern Colorado Endoscopy Center

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. This notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information (PHI) and includes provisions outlined in the 2013 HIPAA Final Omnibus Rule.

Your Protected Health Information
We may collect, use and share your PHI for the following reasons:

For payment: We use and share PHI to manage your account or benefits and to obtain reimbursement for the health care services we provide.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you receive.

For treatment activities: We use and share PHI to ensure you receive the treatment you need.

To you: We must give you access to your own PHI. We may send you reminders about required follow-up care.

To others: You may tell us in writing that it is okay for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is okay, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is okay, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be used to report certain information to the U.S. Food & Drug Administration about medical devices that break or malfunction.

Authorization: We will obtain permission from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may withdraw your authorization, in writing, at any time. We will then stop using your PHI for that purpose. If we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

How We Protect Information
We are dedicated to protecting your PHI and have set up a number of policies and practices to make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to perform their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept.

Your Rights: You may:

- Receive a copy of this Notice of Privacy Practices
- Request limits on disclosure of your PHI
- Receive access to view some or all of your medical record
- Receive a paper or electronic copy of your medical record within 30 days of your documented request
- Request an amendment to your PHI
- Expect your record to be amended within 60 days of your request
- Restrict disclosure of PHI to a health plan when you pay in full at the time of service
- Receive a record of how we have used and/or shared your health information
- Receive information on how to file a complaint if you feel your privacy has been violated
- Opt out of fundraising efforts (when applicable)

We will:

- Not sell your PHI
- Notify you in the event of a breach of your PHI

Contact for further information concerning our privacy practices: You may contact the Privacy Officer at (970) 573-7555.
Complaints: If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health & Human Services. We will not take action against you for filing a complaint.

Rev. 03/2020

NORTHERN COLORADO
ENDOSCOPY
CENTER

ATTENTION:
If you speak one of the following languages, assistance is available to you free of charge. Please ask for assistance from a staff member.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Pida asistencia de un empleado.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama

Persian (Farsi): **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با

Ibo: Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na