Preparation Instruction for a Colonoscopy with SUPREP
Pacific Gastro Health

You are scheduled for a colonoscopy on _____, _____with Dr. Ferdows. Please arrive at _____.

1. On _____, restrict aspirin and aspirin-like products (such as: Ibuprofen, Motrin, Advil, Aleve, Ticlid, Plavix etc.), and NSAID (anti-inflammatory medication). Acetaminophen (Tylenol) is permitted. Pick up SUPREP at your pharmacy, a prescription has been ordered for you.

2. On _____&_____, do not have whole grain and high fiber foods until after your procedure is completed. This includes such foods as nuts, seeds, vegetables, whole grain breads etc. You can have meat, fish, and chicken, white rice, white or low fiber bread, pasta, dairy products etc. Fruits ok, just **no** apples, oranges, or berries.

3. On _____, begin a **clear liquid diet**. Please see attached sheet for a list of these. Dairy and orange juices are not permitted. Avoid any red or purple colored liquid or jello.

4. On _____@_____ follow the instructions on the attached sheet to begin drinking SUPREP. SUPREP may only be mixed with water.

5. On_____@_____ follow the instructions on the attached sheet to begin drinking SUPREP. SUPREP may only be mixed with water.

   ****<u>When your prep is completed you should be passing yellow liquid for stool</u>. If this is not what you see please tell the receptionist when you check in for your procedure.**

6. On _____, at _____, you can **<u>NOT</u>** have anything else to eat or drink until after your procedure is completed.

Concern for your safety makes us insist that you have someone to drive you home. If you have not arranged for a driver, the procedure will be postponed. You will be ready to go home 3-3 ½ hours after your arrival. Your driver will have to come to Same Day Services to pick you up. You will not be allowed to drive for 24 hours.

To reschedule or cancel your procedure, we require that you notify us 3 business days in advance or you will be charged a $75.00 fee. Ph 360-823-0880

Authorization for the Use or Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent
- The patient has been provided with a Grievance procedure

Advance Directives: Statement of Limitation

- This facility does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney.

Signature of Patient: _____ Date:_____ Time:_____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Pacific Gastro Health. I hereby authorize said assignee to release all information necessary to secure payment. I understand Mehdi Ferdows, MD maintains a financial interest in Pacific Gastro Health.

I understand that I am financially responsible for all charges not paid by said insurance, including, but not limited to, non-covered services and cosmetic procedures.

A photocopy of this assignment is to be considered as valid as an original. This assignment will remain in effect until revoked by me in writing.

Signature of Patient: _____ Date: _____ Time:_____

Patient label

Advance Notice Patient Attestation

In accordance with Medicare's Condition of Coverage for Ambulatory Surgical Centers, the following information has been provided to you, verbally and in writing, prior to procedure at the Surgery Center.

1. Statement of Financial Interest: I was advised that Mehdi Ferdows, MD maintains a financial interest in this Surgery Center.

2. Statement of Patient's Rights: A copy of the Patient's Rights and Responsibilities and Grievance Procedure has been provided to me prior to the date of my initial procedure at this Center.

3. Advance Directive: Statement of Limitation: This facility does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney.

_____ _____ _____

Patient Signature Date Time

PACIFIC GASTRO HEALTH

Patient Rights

As a patient, you have the right:

- To have access to the patient rights and responsibilities established by Pacific Gastro Health.
- To see posted written notice of the patient rights in a place or places within the facility likely to be noticed by patients (or their representative, if applicable) waiting for treatment. The written poster will include name, address, and telephone number of a representative of the state agency to whom the patient can report complaints, as well as the website for the Office of the Medicare Beneficiary Ombudsman.
- To be treated with respect, consideration and dignity.
- To have access to spiritual care while at the center, if desired.
- To resolution of problems with care decisions, and any complaint resolution.
- The right to be involved with all aspects of their care including refusing care and treatment an resolving problems with care decisions.
- If communication restrictions are necessary for patient care and safety, the facility will document and explain the restrictions to the patient and family.
- To be respected for your cultural, spiritual beliefs and personal values, beliefs and preferences.
- To refuse care and/or treatment
- To effective communication. The Center communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that fits the patient's need.
- To receive information in a manner tailored to the patient's age, language, and ability to understand. The Center provides interpreting and translation services.
- To be provided appropriate security and privacy. Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.
- To access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.
- To receive care in a safe setting.
- To refuse participation in experimental research and not fear hindering your access to care if you refuse to participate.
- To pain management.
- To be free from all forms of abuse, harassment and neglect.
- To have access to protective services.
- To be fully informed about a treatment or procedure and the expected outcome before the procedure is performed.
  Patients are provided, to the degree known, complete information, concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or a legally authorized person.
- The Center involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.
  The Center provides the patient or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the patient needs in order to participate in current and future health care decisions.
- The Center informs the patient or surrogate decision-maker about unanticipated outcomes of care, treatment.
- To have the opportunity to participate in decisions involving your healthcare, treatment, or services, except when such participation is contraindicated for medical reasons. The Center involves the

patient's family in care, treatment, or services decisions, to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.

- To be informed of your right to change your provider if other qualified providers are available.
- To have appropriate information regarding the absence of malpractice insurance coverage.
- To truthful marketing and advertising regarding the competence and capabilities of the organization.
- To exercise your rights without being subject to coercion, discrimination, reprisal, or interruption of care that could adversely affect you and the right to complain about your care/treatment without fear of retribution or denial of care.
- To information about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations.
- To receive in advance of the date of the procedure the Center's policies on advance directives, including a description of applicable state health and safety laws and if requested, official state advance directive information forms.
- To receive written information about your physician's possible ownership in the Surgery Center. Patients are informed about physician ownership prior to the procedure.
- To information regarding fee for services and payment policies.
- To information regarding the services available at the organization, provisions for after-hour emergency care, and the credentials of healthcare professionals.
- If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative designated by the patient, in accordance with the state law, may exercise the patient's rights to the extent allowed by state law.

Advance Notice of Rights

The patient has the right to receive verbal and written notice in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. The Center gives brochures to each patient being admitted with the Center's written policies and the nurse making the preoperative call informs the patient verbally.

Patient Responsibilities

As a patient, you have the responsibility

- To provide complete and accurate information to the best of your ability about your health, any medications, including over the counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by your provider.
- To provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by your provider.
- To inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- To accept personal financial responsibility for any charges not covered by your insurance.
- To be respectful of the health care providers and staff, as well as other patients.

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already begun in accordance with patient wishes, advance directive or health care power of attorney.

Disclosure of Ownership

Pacific Gastroenterology, including Pacific Gastro Health Surgery Center, is a Limited Liability Corporation (LLC), this is owned by: Mehdi Ferdows, MD.

Grievance Policy

Pacific Gastro Health strives to provide high quality of care and achieve patient satisfaction. Patient grievances/complaints provide a means to measure achievement of this goal and to identify a need for performance improvement. Patients shall be provided with a means to register a complaint concerning any aspect of the service/care provided by the center.

Each patient shall receive a written patient questionnaire upon discharge giving him/her an opportunity to evaluate his/her care.

Any patient may express his/her concerns through the said Questionnaire, verbally or by a simple informal complaint. Such a complaint may be registered by telephone, in writing, verbally or in person to any member of the center staff. The patient will be actively involved with the grievance process. All complaints received by the center personnel shall be forwarded to the Clinical Director or his/her designee the same day. The Clinical Director or his/her designee will address the concern within three 14 days or less.

If subsequent to this contact by the center, the patient continues to have a concern, the patient may submit the complaint or grievance to the Medical Director. The Medical Director will consider the submitted grievance and may request additional information or documentation.

Once the collection of relevant information for the grievance is determined to be complete, the Medical Director will respond to the grievance in writing within fourteen (14) days. If the Medical Director is not able to make a determination within this fourteen (14) day period, he/she will notify the patient in writing regarding the status of his/her grievance.

To report a grievance:

Clinical Director: Miriam Lester, RN
PHONE: 360-823-0880

To Report a Concern:

Washington State Dept. of Health
101 Israel Road SE Tumwater, WA 98501
Phone: 360-236-4700
HSQAComplaintintake@doh.wa.gov

Information is also available via:

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

PACIFIC GASTRO HEALTH
8506 E. MILL PLAIN BLVD.
VANCOUVER, WA 98664

ASC HOURS:
Fridays 7am to 5pm