GASTROINTESTINAL
ASSOCIATES, P.C.

IMPORTANT: Please read packet in full. Fill out all needed information and mail back paperwork so it arrives 48 hours prior to procedure. If you are not able to return your information by mail on time please visit https://gia.mygportal.com/PP6-1-10/Account/LogOn to complete online.

Dear_____,

Your colonoscopy with Dr._____ is scheduled for:

Date: _____

Arrival Time: _____ for _____ appointment.

Location: _____ 1311 Dowell Springs Blvd, Knoxville, TN 37909

_____ 629 Delozier Way, Powell, TN 37849, Suite 2

_____ 11440 Parkside Dr, Knoxville, TN 37934, First Floor, Suite 100

Please follow all dietary instructions in this packet and NOT the instructions provided in the prep box

If you are new to our practice or have not been seen in over one year, you must complete the enclosed forms and mail or bring them back to one of our offices as soon as possible so that we will receive no later than 48 hours prior to your starting your prep. ***If you are not able to return your information by mail on time please visit https://gia.mygportal.com/PP6-1-10/Account/LogOn to complete online.*** The information sheet is needed to verify your insurance information and obtain necessary referrals or pre-certification. This will also allow us to provide you with information on estimated out of pocket expenses prior to your colonoscopy. Please be sure to bring your insurance cards and driver's license to your appointment. We participate with a large number of insurance carriers but if you have a co-pay or have not met your deductible, you will need to be prepared to pay the unmet portion on the day of your procedure. The medical forms will give us your past and present medical history, as well as a list of your current medications and allergies.

GASTROINTESTINAL ASSOCIATES, P.C.

Colonoscopy Bowel Prep Instructions - **Golytely**

Procedure Date / Start Time _____
Your ARRIVAL Time _____

Procedure Location

O Main Office (Dowell Springs Blvd) 0 North Office (Delozier Way) 0 West Office (Parkside Dr)

Planning for the Procedure:

- **You will need a responsible driver** to take you home. You may not drive at all on the day your procedure is performed. We will not sedate you ***unless*** we have the name/phone# of the person who is taking you home.
- Your entire visit at our office on the day of your procedure may last up to 3 to **4** hours. Please advise your driver that they must remain in the unit or nearby during your entire visit.
- If you wear ***dentures*** -- for safety reasons, you will be expected to ***remove*** them before your procedure.
- Dress comfortably in clothes that can be easily removed/folded.
- If you have not received your bowel prep materials (laxative kit), or if you must cancel/reschedule your appointment, please call our office at 865-588-5121.

Supplies needed:

- Fill your prescription for ***Golytely*** at your local pharmacy and purchase 1 box of Dulcolax tablets (at least 3 tablets).

DRINKING THE PREP - Follow the instructions exactly as written to ensure a successful procedure.

7 days before your colonoscopy:

- If you take aspirin (325 mg or less) or NSAIDs (Advil, Aleve, Motrin, Mabie or ibuprofen), you may continue to take them as usual.
- If you take a blood thinner or high dose aspirin (greater than 325 mg), see attached sheet for instructions. Check with your doctor to be sure it is safe to hold your medication.
- Stop taking iron supplements and multivitamins that contain either iron or Vitamin E.

3 days before your colonoscopy:

- Stop eating popcorn, corn, seeds, nuts, beans, fruits with small seeds, and celery.
- If you take oral meds for diabetes, contact your doctor to see if your dose needs to be adjusted on the day before your procedure.

1 day before your colonoscopy:

- Begin a clear liquid diet (see table below). ***No solid food is allowed on this day.*** Drink at least 8 glasses of water from 8 AM-4 PM.
- **At 9 AM,** fill the ***Golytely*** jug with lukewarm water up to the fill line, put the lid on, and shake to dissolve. Refrigerate.
- **At 4 PM,** take the jug out of the refrigerator.
- **At 5 PM,** begin drinking the solution by consuming 1 glass every 15 minutes until½ of the jug is finished. If you become nauseated, try drinking at a slower pace. It may help if you drink it thru a straw. Refrigerate the remaining solution in the jug.
- **At 10 PM,** take 3 Dulcolax tablets.

Clear liquids which are allowed:

Gatorade, Pedialyte, or Powerade
Coffee or tea (No milk or non-dairy creamer)
Carbonated and non-carbonated soft drinks
Kool-Aid or other fruit-flavored drinks
Apple juice, white cranberry juice, or white grape juice
Jell-O, popsicles

Non-clear liquids - NOT allowed:

Red or purple items of any kind
Alcohol
Milk or non-dairy creamers
Juice with pulp
Any liquid you cannot see through

Day of your colonoscopy:

- You will need a responsible party to take you home. You may not drive on the day your procedure is performed. We will not sedate you unless we have the name/phone number of the driver taking you home. Uber, Lyft, taxi, etc.. are not considered a responsible party and therefore are not allowed unless your provider has approved this prior to your procedure.
- Four (4) hours before your procedure start time, drink the remaining ***Golytely*** solution at a rate of 1 glass every 15 minutes. Finish the remaining solution no later than 2 hours before your procedure start time. **DO NOT** use any form of tobacco (cigarettes, chew, dip, vape) on the day of your procedure to avoid risk of cancellation.
- Two (2) hours before your procedure start time, you may take your morning meds with 1-2 sips of water. **DO NOT** drink anything else. **DO NOT** chew gum or eat hard candy. **DO NOT** wear any perfume or cologne. If you have asthma, bring your inhalers. If you take injectable insulin, bring it with you.

Additional helpful tips:

1. Stay near a toilet! You will have diarrhea, which can be quite sudden. This is normal.
2. If you have nausea or vomiting with the prep, give yourself a 30-60 minute break, rinse your mouth or brush your teeth, then resume drinking the prep.
3. Anal skin irritation or hemorrhoid inflammation may occur. If this happens, treat it with over-the-counter-remedies, such as hydrocortisone cream, baby wipes, Vaseline, Desitin, or TUCKS pads. Avoid products containing alcohol. If you have a prescription for hemorrhoid cream, you may use it. Do not use suppositories.

https://tn-010-c.ggastrocloud.com/gGastro/?status=undefined&message= 1/1

- If you take aspirin (325 mg or less) or NSAIDs (Advil, Aleve, Motrin, Mobic or ibuprofen), you may continue to take them as usual.
- If you take blood thinner or high dose aspirin (greater than 325 mg), see attached sheet for instructions. Check with your doctor to be sure it is safe to hold your medication.
- Stop taking Iron supplements and multivitamins that contain either Iron or Vitamin E.
- **TYLENOL** products are okay to take prior to your colonoscopy.

PLEASE DO NOT STOP ANY BLOOD THINNERS UNTIL YOUR PRESCRIBING PHYSICIAN APPROVES THIS

This list is simply our recommendation and if your physician does not want you to stop your blood thinner, you will need to notify your physician's nurse at our office.

If you are diabetic, please contact your primary care or prescribing physician for recommendations on how to manage your diabetic medications prior to your colonoscopy. Usually patient do not take their diabetic medications on the day of the procedure but should bring the medication to the appointment if they choose to eat after the exam prior to returning home.

IF YOU HAVE AN IMPLANTED DEFIBRILLATOR WE CANNOT PERFORM YOUR COLONOSCOPY IN OUR SURGERY CENTER

Please notify your physician's nurse as soon as possible so that your procedure can be rescheduled in a hospital setting. If you have a pacemaker **ONLY** we can perform your colonoscopy as planned in our surgery center.

If you weight over 400 pounds or have a BMI of 50 or greater, call your physician's nurse at this office to see if we can safely perform your colonoscopy in an office setting.

Enclosed you will find the colonoscopy prep that your physician prefers. Please read all of the instructions carefully as soon as possible so that if you have questions, you will have time to call the office. Many of our colonoscopy preps require prescription laxatives. If your prep contains a prescription, please take it to your pharmacy several days before your appointment. **IT IS EXTREMELY IMPORTANT THAT YOU FOLLOW ALL INSTRUCTIONS EXACTLY AS THEY ARE WRITTEN** in order to obtain a satisfactory exam.

If you have questions regarding a medical condition or the preparation instructions, please call our office (865) 588-5121 and ask for your physician's nurse. You will need to leave a message and your call will be returned as soon as possible.

If you need to cancel or reschedule your appointment, please call (865) 588-5121 and ask for scheduling.

Thank you for allowing us to participate in your care.

Please reference the tables below when considering how long to stop your anti-coagulant and Injectable diabetic/weight loss medications before your procedure. Please also consult with your primary care doctor, your heart/lung specialist, or the prescribing physician for your anti-coagulant and diabetic medications for further clarification on the safety of stopping your medication (unless we've already done this for you). If your doctor denies you permission to stop your medication, please let your gastroenterologist know.

ANTI - COAGULANT MEDICATIONS	
Brilinta (ticagrelor)	Hold for 5 days prior
Coumadin (warfarin)	Hold for 5 days prior
Effient (prasugrel)	Hold for 7 days prior
Eliquis (apixaban)	Hold for 2-4 days (normal kidney function - 2 days)
Plavix (clopidogrel)	Hold for 5 days prior
Pradaxa (dabigatran)	Hold for 2-4 days (normal kidney function - 2 days)
Savaysa (edoxaban)	Hold for 1 day prior
Xarelto (rivaroxaban)	Hold for 1 day prior
Pletal (cilostazol)	Hold for 2 days prior
Aggrenox (aspirin & dipyridamole)	Hold for 7 days prior
Aspirin	Do not stop 81 or 325 mg. For 500 mg or more, **STOP** for 7 days

DIABETIC AND WEIGHT LOSS - INJECTABLE MEDICATIONS	
Byetta (exenatide)	Hold on day of procedure (twice daily injection)
Victoza (liraglutide)	Hold on day of procedure (once daily injection)
Tanzeum (albiglutide)	Hold for 7 days prior to procedure (once weekly injection)
Trulicity (dulaglutide)	Hold for 7 days prior to procedure (once weekly injection)
Lixumia (lixisenatide)	Hold on day of procedure (once daily injection)
Beinaglutide	Hold on day of procedure (three times daily injection)
Ozempic (semaglutide)	Hold for 7 days prior to procedure (once weekly injections)
Fu Laimel (peg-loxenatide)	Hold for 7 days prior to procedure (once weekly injection)
Mounjaro (tirzepatide)	Hold for 7 days prior to procedure (once weekly injection)
Wegovy (semaglutide)	Hold for 7 days prior to procedure (once weekly injection)
Bydureon (exenatide)	Hold on day of procedure (twice daily injection)
Rybelsus (semaglutide)	Hold for 7 days prior to procedure (once weekly injection)
Soliqua (lixisenatide)	Hold on day of procedure (once daily injection)
Xultophy (Insulin degludec/liraglutide)	Hold on day of procedure (once daily injection)

GASTROINTESTINAL ASSOCIATES, P.C.
PATIENT INFORMATION RECORD

Date _____ **SS#** _____ **Age** _____

Name: Mr. / Mrs. / Miss / Ms. _____
Last First MI

Address: _____
Street Address (required) P.O. Box

_____
City State Zip County

Is the above address an Assisted Living Facility or Nursing Home? Yes ☐ No ☐

If yes, name of facility: _____

Telephone: **Home** _____ **Employer** _____
Work _____ **Employer Address** _____
Cell _____ _____

Text Appt. Reminders *Yes* ☐ *No* ☐

Preferred Method of Communication **Telephone** ☐ **Email** ☐ **Letter** ☐

Patient's Date of Birth _____

Patients's E-mail Address: _____

Emergency Contact Name: _____ **Phone #:** _____

Sex: **Male** **Female**

Marital Status: (check one) Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Other ☐

Spouse: **Name** _____ **DOB:** _____

Employer _____

Race: (check one) ☐ White / Caucasian ☐ Native Hawaiian / Other Pacific Islander ☐ American Indian or Alaskan Native
☐ Black / African American ☐ Asian ☐ More than one race ☐ Pt. refuses to report or unavailable

Ethnicity: ☐ Not Hispanic ☐ Hispanic or Latino ☐ Pt. declined or unavailable

Preferred Language _____

Referred by: **Doctor** _____ **Address** _____
Friend _____ **Newspaper** _____ **Other** _____ (specify)

Primary Care Physician _____

Insurance Information

Primary insured's name _____ **Date of birth** _____
Primary insured's insurance company _____
Primary insured's ID number _____ **Group #** _____
Secondary insured's name _____ **Date of birth** _____
Secondary insured's insurance company _____
Secondary isured's ID number _____ **Group #** _____
Do you have a Living Will or Advance Directives for Healthcare? _____
If yes, where is the document located? _____
Do you have a Durable Power of Attorney for Healthcare? _____
If yes, where is the document located? _____
Would you like information regarding a living will? _____

GASTROINTESTINAL
ASSOCIATES, P.C.

Address: 1311 Dowell Springs Blvd. Knoxville, TN 37909
Phone: 865-588-5121
Fax: 865-588-2126

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Notes:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ No Preference ☐ Email ☐ Letter ☐ Patient declines to specify Other:_____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Penicillins ☐ Sulfa ☐ Iodine Compounds ☐ Latex ☐ morphine (PF)

☐ Codeine Sulfate Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name _____ Address _____ Phone _____

Immunizations

- ◯ None
- ◯ Flu vaccine When:_____
- ◯ Hep A When:_____
- ◯ Hep B When:_____
- ◯ Pneumovax When:_____
- ◯ TB skin test When:_____
- ◯ COVID-19 When:_____

Past or Present Medical Conditions

- ◯ None
- ◯ Anemia
- ◯ Anxiety
- ◯ Alzheimer's Dementia
- ◯ Asthma
- ◯ Arthritis (non-Rheumatoid)
- ◯ Atrial Fibrillation
- ◯ Barrett's Esophagus
- ◯ Bipolar Disorder
- ◯ Blood Clot - Leg (DVT)
- ◯ CANCER
- ◯ Cirrhosis
- ◯ Colon Cancer
- ◯ Colon Polyps
- ◯ Congestive Heart Failure
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Crohn's Disease
- ◯ Dementia, type unspecified
- ◯ Depression
- ◯ Diabetes Mellitus
- ◯ Diverticulosis
- ◯ Fibromyalgia
- ◯ GERD / Reflux
- ◯ Glaucoma
- ◯ Gout
- ◯ Hepatitis C
- ◯ MI (Heart Attack)
- ◯ Hypertension
- ◯ Hyperlipidemia
- ◯ HIV
- ◯ Hypothyroidism
- ◯ IBS
- ◯ Kidney Failure
- ◯ Kidney Stones
- ◯ Lupus (SLE)
- ◯ Migraine Headaches
- ◯ Osteoporosis
- ◯ Parkinson's
- ◯ Psoriasis
- ◯ Pulmonary Embolism
- ◯ Rheumatoid Arthritis
- ◯ Scleroderma
- ◯ Seizure disorder
- ◯ Obstructive Sleep Apnea
- ◯ Peptic Ulcer Disease
- ◯ Stroke (CVA)
- ◯ TIA
- ◯ Ulcerative Colitis

Other:_____ Other:_____

Other:_____

Previous Procedures

- ◯ None
- ◯ Abdominal Hernia Repair
- ◯ Anal Fissure Repair
- ◯ Aneurysm Repair
- ◯ Appendectomy
- ◯ Back Surgery
- ◯ Bladder Lift/Tack
- ◯ Breast Augmenation
- ◯ Breast Reduction
- ◯ Cardiac Cath
- ◯ Cardiac Stent
- ◯ Carotid Surgery/Stent
- ◯ Cataract Removal
- ◯ C-Section
- ◯ Colectomy - partial
- ◯ Colectomy - total
- ◯ Colostomy Bag
- ◯ Coronary Bypass (CABG)
- ◯ D and C
- ◯ Defibrillator Placement
- ◯ Exploratory Laparotomy
- ◯ Gastrectomy - Partial
- ◯ Gastric Bypass Surgery
- ◯ Gallbladder Removal
- ◯ Hemorrhoid Surgery
- ◯ Hiatal Hernia repaired
- ◯ Hip Replacement
- ◯ Hysterectomy
- ◯ Knee Surgery
- ◯ Gastric Lap Band
- ◯ Laparoscopy
- ◯ Mastectomy
- ◯ Ovary Removal
- ◯ Pacemaker Insertion
- ◯ Prostate Removal
- ◯ Sinus Surgery

☐ Splenectomy ☐ Thyroidectomy ☐ Tonsillectomy ☐ Tubal (BTL) ☐ Valve (Heart) Replacement

Other: Other: Other: Other: Other:

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy ☐ Endoscopy ☐ Ultrasound ☐ HIDA scan ☐ CT Scan

When: When: When: When: When:

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac Disease
☐ Colon polyps
☐ Gastric Cancer
☐ Liver disease
☐ Pancreatitis
☐ Ulcerative colitis
☐ Colon cancer
☐ Crohn's disease
☐ GI Cancers
☐ Pancreatic Cancer
☐ Stomach Cancer

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	○	○	○	○	○	○
Crohn's / Regional Enteritis	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Gastric Cancer	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Social History

Occupation: Number of Children:

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type	Quantity	Number	Frequency

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Review Of Systems

Cardiovascular

◯ None

	Y	N
chest pain	◯	◯
irregular heart beat	◯	◯
passing out/fainting	◯	◯

Constitutional

◯ None

	Y	N
fatigue	◯	◯
weight loss	◯	◯
fever/chills	◯	◯

Integumentary

◯ None

	Y	N
hives	◯	◯
itching	◯	◯
rash	◯	◯

ENMT

◯ None

	Y	N
sore throat	◯	◯
mouth sores	◯	◯
hoarseness	◯	◯

Gastrointestinal

◯ None

	Y	N
abdominal pain	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
trouble swallowing	◯	◯
blood in stool	◯	◯

Genitourinary

◯ None

	Y	N
blood in urine	◯	◯
urinary incontinence	◯	◯
prostate trouble	◯	◯

Endocrine

◯ None

	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Musculoskeletal

◯ None

	Y	N
arthritis	◯	◯
back pain	◯	◯
muscle weakness	◯	◯

Neurological

◯ None

	Y	N
dizziness	◯	◯
frequent headaches	◯	◯
seizures	◯	◯

Hematologic/Lymphatic

◯ None

	Y	N
easy bruising	◯	◯
enlarged lymph nodes	◯	◯
prolonged bleeding	◯	◯

Psychiatric

◯ None

	Y	N
anxiety	◯	◯
depression	◯	◯
panic attacks	◯	◯

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

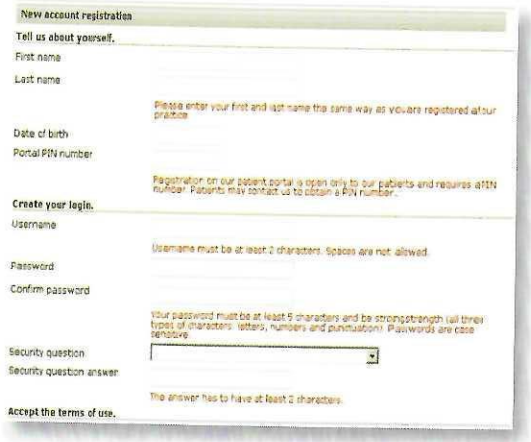
Signature

Signature Date

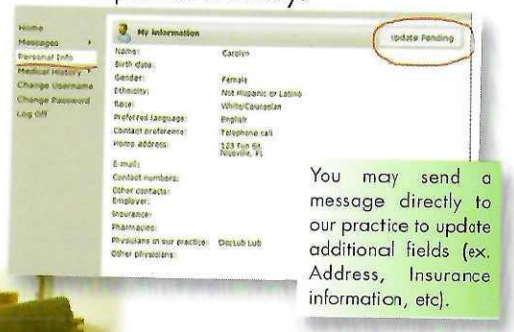
How do I register?

Step 1: You will receive an invitation email from our practice with a link and unique ID that will take you through the registration process.

Step 2: Click on the link in the invitation email to create a unique user ID and password.



Step 3: Once registered, complete your medical, family and social history if not completed recently.



You may send a message directly to our practice to update additional fields (ex. Address, Insurance information, etc).

Step 4: Click submit to send your information directly to our office

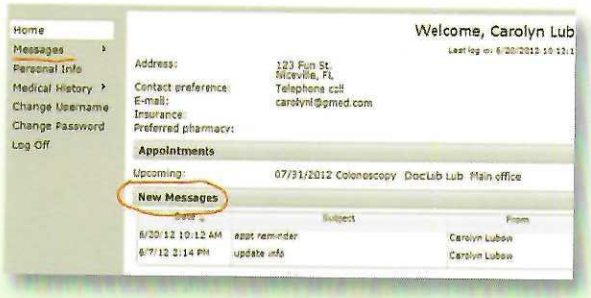
How do I...

Send a message to my Doctor's office?

- Click on the message tab.
- Click "new" and compose your message.
- Remember to hit send.

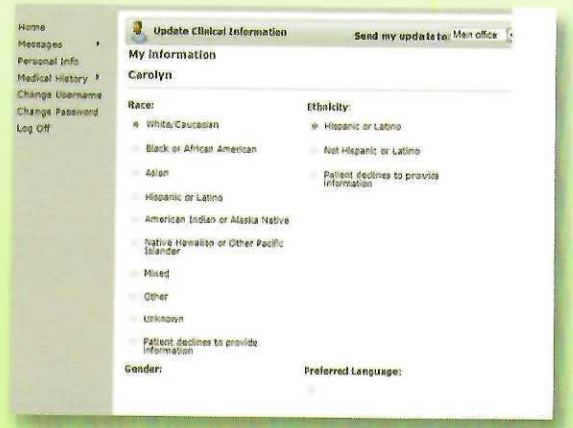
Receive messages through gPortal?

- You will receive a notification email when you have a message waiting in ***gPortal***.
- Click on the message tab.
- Click on "new messages" to view your messages.



Update my personal information?

- Click "update" button.
- Click on the "personal info" tab.
- Change the information you want



How do I...

Reset my password?

- Click on the "change password" tab.
- Enter username, DOB and registered email address.

Frequently Asked Questions

Q: Can I schedule my appointment online through gPortal?

A: You may send a request to schedule your appointment and our practice will contact you.

Q: Does gPortal allow me to send a message directly to my physicians office?

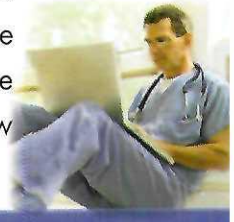
A: Yes, you may send a message directly to our office through gPortal. We will make sure your message reaches the correct person so that your question is answered.

Q: Can I refill my prescriptions through gPortal?

A: No, you must go directly through your pharmacy in order to refill your prescription.

Q: What do I do if my account is locked due to too many failed log-in attempts?

A: Click on the change password tab and follow the instructions to create a new password.



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

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

Complaints/Grievances:

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

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

David Harano, CEO
P.O. Box 59002,
Knoxville, TN 37950-9002
865-588-5121

You may contact the state to report a complaint:

Tennessee Department of Health
710 James Robertson Parkway
Nashville, TN 37243
615.741.3011

State Web site: http:// tn.health@tn.gov

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.
Medicare Ombudsman Web site:

www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

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

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

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:

AAAHC
3 Parkway N Suite 201
Deerfield, IL 60015
Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

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

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:

Johnny Altawil, MD
J. Matthew Moore, MD
William F. Ergen, MD
Steven J. Bindrim, MD
Raj I. Narayani, MD
Jeffrey S. Gilbert, MD
John M. Haydek, MD
Hannah Jones, DO
Maria B. Newman, MD
Ramanujan Samavedy, MD
Kevin P. Meyers, MD

The Endoscopy Center
1311 Dowell Springs Blvd., Suite 200
Knoxville, TN 37909
865-588-5121

The Endoscopy Center North
629 Delozier Way
Powell, TN 37849

The Endoscopy Center West
11440 Parkside Drive
Knoxville, TN 37934

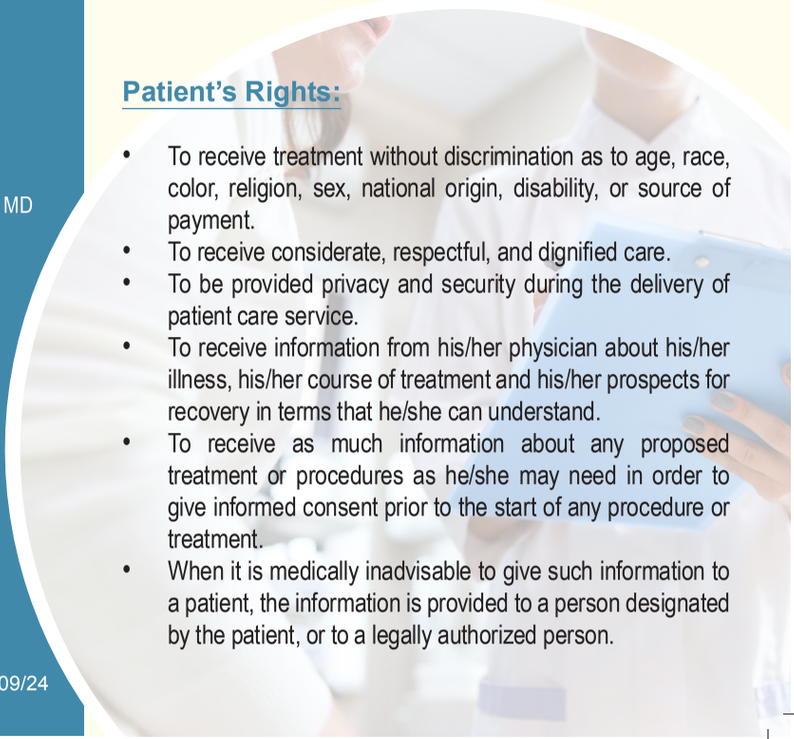
Label for Medical Records

G001 Rev 09/24

THE ENDOSCOPY CENTER

Patient's Rights and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.



Patient's Rights:

- To receive treatment without discrimination as to age, race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful, and dignified care.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To be informed of their right to change providers if other qualified providers are available.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/ her patient record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.

Patient Responsibilities:

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

If you need an interpreter:

If you will need an interpreter, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure. The Interpreter must be 18 years or older.

Rights and Respect for Property and Person Privacy and Safety

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Personal privacy.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Receive care in a safe setting.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Be free from all forms of abuse or harassment.
- Confidentiality of personal medical information.

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

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

The Endoscopy Center مركز التنظير يتوافق مع قوانين الحقوق المدنية الاتحادية وعدم التمييز على أساس العرق أو اللون، والأصل القومي، السن، الإعاقة أو الجنس

The Endoscopy Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Tennessee Statues 32-11-101-113. In the state of Tennessee, all patients have the right to make their own health care decisions. All patients can remain in charge of their health care, even after they can no longer make decisions for themselves by creating a document called and "Advance Care Plan". You can use a Living Will/Advance Care Plan to tell your doctor you want to avoid life-prolonging interventions such as cardiopulmonary resuscitation (CPR), kidney dialysis or breathing machines. You can use this form to tell your doctor you just want to be pain free and comfortable at the end of life.

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.