



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.



Colonoscopy Bowel Prep Instructions - SuTab

Procedure Date / Start Time _____
Your ARRIVAL Time _____

Procedure Location _____

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

Planning for the Procedure:

- You will need a responsible party 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.
- Didn't get bowel prep materials (laxative kit)? Need to cancel/reschedule appointment? - Please call our office at 865-588-5121.

Supplies needed:

- Your **SuTab** prep kit will be mailed to you by GiftHealth Specialty Pharmacy.

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, Mobic 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:

- For breakfast, lunch and dinner, you should only consume clear liquids noted in the table below (list A). **Avoid red or purple-colored liquids or any of the liquids in list B.** Drink at least 8 glasses of water from 8 AM-4 PM.
- **At 5 PM**, open the first bottle of 12 tablets and fill the provided container with 16 oz of water (up to fill line). Swallow **1 tablet every 2 minutes** and follow with a few sips from the 16 oz glass of water. Finish all 12 tablets and the entire 16 oz of water within 20-30 minutes. At 1 hour after the last tablet was taken, drink another 16 oz of water over 30 minutes. At 30 minutes after finishing the 2nd container of water, drink another 16 oz of water over 30 minutes.

A

Clear liquids which are allowed:

Gatorade, Pedialyte, or Powerade
Coffee or tea
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, clear broth

B

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.
- **Five (5) hours before your procedure start time**, open the 2nd bottle of 12 tablets and fill the provided container with 16 oz of water (up to fill line). Swallow **1 tablet every 2 minutes** and follow with a few sips from the 16 oz glass of water. You should finish all 12 tablets and the entire 16 oz of water within 20-30 minutes. At 1 hour after the last tablet was taken, drink another 16 oz of water over 30 minutes. At 30 minutes after finishing the 2nd container of water, drink another 16 oz of water over 30 minutes. **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 with over-the-counter-remedies, such as hydrocortisone cream, baby wipes, Vaseline, Desitin, or TUCKS pads. Avoid topical products containing alcohol. If you have a prescription for hemorrhoid cream, you may use it. Do not use suppositories.

- 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-loxenate)	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 _____ Work _____ Cell _____
Employer _____
Employer Address _____

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 insured'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
 ☐ Hep A
 ☐ Hep B
 ☐ Pneumovax
 ☐ TB skin test

When: _____ When: _____ When: _____ When: _____ When: _____

☐ COVID-19

When: _____

Past or Present Medical Conditions

☐ None

<input type="radio"/> Anemia	<input type="radio"/> Anxiety	<input type="radio"/> Alzheimer's Dementia	<input type="radio"/> Asthma	<input type="radio"/> Arthritis (non-Rheumatoid)
<input type="radio"/> Atrial Fibrillation	<input type="radio"/> Barrett's Esophagus	<input type="radio"/> Bipolar Disorder	<input type="radio"/> Blood Clot - Leg (DVT)	<input type="radio"/> CANCER
<input type="radio"/> Cirrhosis	<input type="radio"/> Colon Cancer	<input type="radio"/> Colon Polyps	<input type="radio"/> Congestive Heart Failure	<input type="radio"/> COPD
<input type="radio"/> Coronary Artery Disease	<input type="radio"/> Crohn's Disease	<input type="radio"/> Dementia, type unspecified	<input type="radio"/> Depression	<input type="radio"/> Diabetes Mellitus
<input type="radio"/> Diverticulosis	<input type="radio"/> Fibromyalgia	<input type="radio"/> GERD / Reflux	<input type="radio"/> Glaucoma	<input type="radio"/> Gout
<input type="radio"/> Hepatitis C	<input type="radio"/> MI (Heart Attack)	<input type="radio"/> Hypertension	<input type="radio"/> Hyperlipidemia	<input type="radio"/> HIV
<input type="radio"/> Hypothyroidism	<input type="radio"/> IBS	<input type="radio"/> Kidney Failure	<input type="radio"/> Kidney Stones	<input type="radio"/> Lupus (SLE)
<input type="radio"/> Migraine Headaches	<input type="radio"/> Osteoporosis	<input type="radio"/> Parkinson's	<input type="radio"/> Psoriasis	<input type="radio"/> Pulmonary Embolism
<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Scleroderma	<input type="radio"/> Seizure disorder	<input type="radio"/> Obstructive Sleep Apnea	<input type="radio"/> Peptic Ulcer Disease
<input type="radio"/> Stroke (CVA)	<input type="radio"/> TIA	<input type="radio"/> Ulcerative Colitis	Other: _____	Other: _____

Previous Procedures

☐ None

<input type="radio"/> Abdominal Hernia Repair	<input type="radio"/> Anal Fissure Repair	<input type="radio"/> Aneurysm Repair	<input type="radio"/> Appendectomy	<input type="radio"/> Back Surgery
<input type="radio"/> Bladder Lift/Tack	<input type="radio"/> Breast Augmentation	<input type="radio"/> Breast Reduction	<input type="radio"/> Cardiac Cath	<input type="radio"/> Cardiac Stent
<input type="radio"/> Carotid Surgery/Stent	<input type="radio"/> Cataract Removal	<input type="radio"/> C-Section	<input type="radio"/> Colectomy - partial	<input type="radio"/> Colectomy - total
<input type="radio"/> Colostomy Bag	<input type="radio"/> Coronary Bypass (CABG)	<input type="radio"/> D and C	<input type="radio"/> Defibrillator Placement	<input type="radio"/> Exploratory Laparotomy
<input type="radio"/> Gastrectomy - Partial	<input type="radio"/> Gastric Bypass Surgery	<input type="radio"/> Gallbladder Removal	<input type="radio"/> Hemorrhoid Surgery	<input type="radio"/> Hiatal Hernia repaired
<input type="radio"/> Hip Replacement	<input type="radio"/> Hysterectomy	<input type="radio"/> Knee Surgery	<input type="radio"/> Gastric Lap Band	<input type="radio"/> Laparoscopy
<input type="radio"/> Mastectomy	<input type="radio"/> Ovary Removal	<input type="radio"/> Pacemaker Insertion	<input type="radio"/> Prostate Removal	<input type="radio"/> 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

<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Gastric Cancer	<input type="checkbox"/> GI Cancers
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Pancreatic Cancer
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Stomach Cancer
<input type="checkbox"/> Ulcerative colitis	

Mother
 Father
 Sister
 Brother
 Grandmother
 Grandfather

Diagnoses

Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's / Regional Enteritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Occupation: _____
 Number of Children: _____

Marital Status

☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Alcohol

☐ None

Type	Quantity	Number	Frequency
Tobacco			
Smoking Status	<input type="radio"/> Current every day smoker <input type="radio"/> Smoker, current status unknown	<input type="radio"/> Current some day smoker <input type="radio"/> Light tobacco smoker	<input type="radio"/> Former smoker <input type="radio"/> Heavy tobacco smoker <input type="radio"/> Never smoker <input type="radio"/> 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

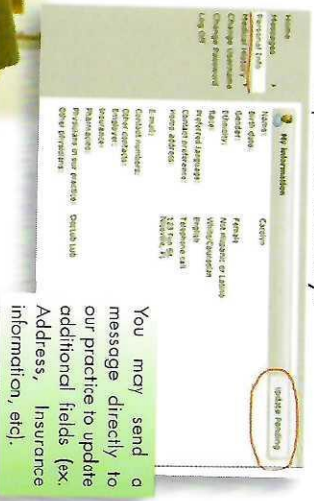
Signature _____ Date _____

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.



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

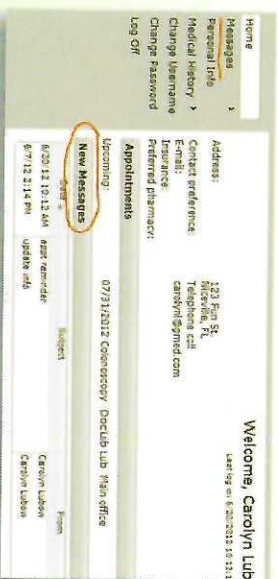
How do I...

Send a message to my Doctor's office?

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

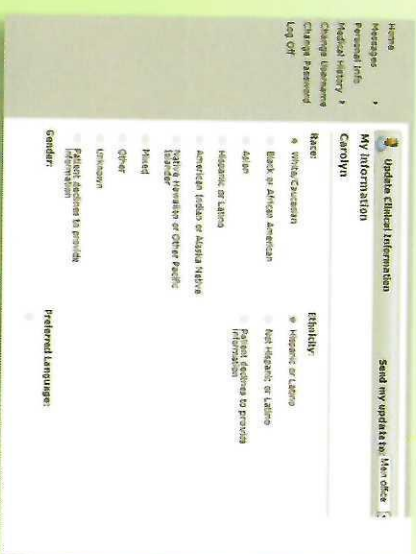
Receive messages through gPortal?

- 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	John M. Haydek, MD
J. Matthew Moore, MD	Hannah Jones, DO
William F. Eitzen, MD	Maria B. Newman, MD
Steven J. Bindrm, MD	Ramanujan Samavedy, MD
Raj I. Narayani, MD	Kevin P. Meyers, MD
Jeffrey S. Gilbert, 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 37834

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.

