



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.

****If your procedure is 11:30am or earlier refer to page 2 of the instructions, if your procedure is 12:00pm or later please refer to page 3 of the instructions.****

****This prep sheet is ONLY for procedures before 12:00pm****



Colonoscopy Bowel Prep Instructions - SuFlave

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.
- 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:

- Your **SuFlave** 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:

- 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 4 PM**, prepare each bottle of **SuFlave** by adding a flavor enhancing packet and lukewarm water up to the fill mark on each bottle. Gently shake both bottles until powder is dissolved, and then refrigerate both bottles. **DO NOT FREEZE.**
- **At 5 PM**, take the 1st bottle out of the refrigerator and drink 8 ounces of the solution every 15 minutes until it is finished. Follow this by drinking 1 additional glass of water (16 ounces) over the next 2 hours. If nausea or bloating occur, slow down your pace of drinking.

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, clear broth

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.
- **Six(6) hours** before your procedure start time, take the 2nd bottle of **SuFlave** out of refrigerator and begin drinking. As with the prior dose, drink 8 oz every 15 minutes until entire bottle is finished. Follow this by drinking a 16 oz glass of water over the next 1 hour. **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 vomiting with the prep, give yourself a 30-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.

Colonoscopy Prep Instructions **Suflave** (Afternoon Scope)

This prep is ONLY for procedures 12:00pm or later

Your arrival time _____
Your procedure time _____ Procedure Date _____

Procedure Location

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

Planning for the Procedure:

- **You will need a 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. 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.
- Your entire visit to 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 facility 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:

- **SuFlave** prep kit will be mailed to you by **Gifthealth** specialty pharmacy. 888-861-7570

DRINKING THE PREP – Follow the instructions exactly as written below 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. If you take a weight loss medication (GLP-1 agonist) please see attached instructions.
- 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:

Sample Meal Plan

Breakfast:	Glass of milk, cream of wheat with milk and white sugar, scrambled eggs and white toast.
Lunch:	Glass of lemonade, white bread sandwich with slice chicken breast, cream cheese or mayonnaise
Dinner (4 PM):	Whitefish fillet with rice or mashed potatoes, or regular Pasta with diced chicken breast and Parmesan cheese, and water, and vanilla ice cream

SAME DAY PREP FOODS ALLOWED:

- Milk, white colored yogurt (no added fruit), mayonnaise, cream, sour cream, butter and margarine, oil for cooking
- White bread/toast, eggs (whole or whites)
- White rice, regular pasta, potatoes (peeled and mashed only), rice noodles
- Rice crackers (plain), white flour, sugar
- Chicken breast (no skin), white fish fillet (no skin)
- Cheese: cream cheese/cheddar/ricotta/feta/cottage/mozzarella/parmesan cheese
- White chocolate, vanilla ice cream
- CLEAR FLUIDS are allowed: water, soda water, mineral water, ginger ale, sports drinks (not red/purple/blue), lemonade, apple juice (no pulp), black coffee/tea, Jell-O (not red) or clear soup (e.g. clear chicken broth)
- **Food NOT ALLOWED** – Anything not listed above

1 day before your colonoscopy:

- Prepare each bottle of **Suflave** by adding a flavor enhancing packet (or omitting it if you prefer to avoid artificial sweeteners) and lukewarm water to the fill mark on each bottle. * You may also use **pulp free** lemon or lime juice for flavoring instead of the flavor enhancing packet. Gently shake both bottles until the powder is dissolved and then refrigerate both bottles.
- At **5pm** drink the 1st bottle of **SuFlave**- Drink the entire mixture- drink 8oz of the solution every 15 minutes until finished, follow with one 16 oz glass of water over the next 2 hours (if nausea or bloating occurs, slow down your pace of drinking)

DAY OF your colonoscopy:

- **At 6am**, drink the 2nd bottle of **SuFlave** – Drink the entire mixture follow the same directions as the prior dose. Finish this solution by **7am**.
- **DO NOT** drink anything else **after 10 AM**. If necessary, you may take your morning meds with 1-2 sips of water. **DO NOT** chew gum or eat hard candy. **DO NOT** use any form of tobacco (cigarettes, chew, dip, vape) on the day of your procedure to avoid risk of cancellation. **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.

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	
<u>Brilinta</u> (ticagrelor)	Hold for 5 days prior
Coumadin (warfarin)	Hold for 5 days prior
<u>Effient</u> (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)
<u>Savaysa</u> (edoxaban)	Hold for 1 day prior
Xarelto (rivaroxaban)	Hold for 1 day prior
<u>Pletal</u> (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)
<u>Tanzeum</u> (albiglutide)	Hold for 7 days prior to procedure (once weekly injection)
Trulicity (dulaglutide)	Hold for 7 days prior to procedure (once weekly injection)
<u>Lixumia</u> (lixisenatide)	Hold on day of procedure (once daily injection)
<u>Beinaglutide</u>	Hold on day of procedure (three times daily injection)
Ozempic (semaglutide)	Hold for 7 days prior to procedure (once weekly injections)
Fu <u>Laimel</u> (peg- <u>loxenatide</u>)	Hold for 7 days prior to procedure (once weekly injection)
<u>Mouniaro</u> (tirzepatide)	Hold for 7 days prior to procedure (once weekly injection)
<u>Wegovy</u> (semaglutide)	Hold for 7 days prior to procedure (once weekly injection)
<u>Bydureon</u> (exenatide)	Hold on day of procedure (twice daily injection)
<u>Rybelsus</u> (semaglutide)	Hold for 7 days prior to procedure (once weekly injection)
<u>Soliqua</u> (lixisenatide)	Hold on day of procedure (once daily injection)
<u>Xultophy</u> (Insulin degludec/liraglutide)	Hold on day of procedure (once daily injection)

- 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	
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Xarelto (rivaroxaban)	Hold for 1 day prior
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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 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

☐ 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: _____

Previous Procedures

☐ None

☐ Abdominal Hernia Repair	☐ Anal Fissure Repair	☐ Aneurysm Repair	☐ Appendectomy	☐ Back Surgery
☐ Bladder Lift/Tack	☐ Breast Augmentation	☐ 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 cancer
☐ Colon polyps	☐ Crohn's disease
☐ Gastric Cancer	☐ GI Cancers
☐ Liver disease	☐ Pancreatic Cancer
☐ Pancreatitis	☐ Stomach Cancer
☐ Ulcerative colitis	

Mother
 Father
 Sister
 Brother
 Grandmother
 Grandfather

Diagnoses

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

Type	Started	Quit	Quantity	Frequency
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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

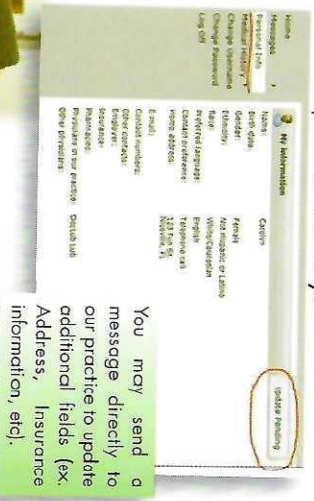
Signature _____ Date _____

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 (AAAHHC). Complaints or grievances may also be filed through:

AAAHHC
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.

