mes Midwest Endoscopy Services LLC

Thank you for choosing Midwest Endoscopy Services, LLC, for your upcoming procedure.

In an effort to make the registration process more efficient, please bring the following items:

- The enclosed paperwork. Some forms are double-sided. Please complete both sides.
- Your insurance card(s) so that we may facilitate filing with your insurance company.
- A photo ID to ensure and protect your identity.

The Medical Plaza is one block south of Dodge Street at 8901 Indian Hills Drive. Parking and entrance are located on the south side of the building off of 90th Street. Please refer to the enclosed pamphlet for a map of our location.

*Please note: the Procedure Center is located on the **lower level** of the Medical Plaza in Suite 100.

If you have informed our scheduling department that you will require interpretive services, these services will be provided by Cyracom, Hope Medical, and approved sign language interpreters for our patients. If you will require these services and have not notified our scheduling department, please contact our office to arrange services.

If you have any questions related to your procedure or preparation, please call your physician's office at (402) 397-7057.

(over)

Patient Label Here

MIDWEST ENDOSCOPY SERVICES, LLC

REGISTRATION FORM

PLEASE FILL OUT THIS FORM **COMPLETELY** AND **LEGIBLY.** This form needs to be presented upon your arrival to the procedure center **along with your photo ID and insurance card(s)**. Thank you.

PATIENT REGISTRATION INFORMATION

Patient Name **AS IT APPEARS ON YOUR INSURANCE POLICY (Be sure to include any prefix, suffix, middle initial, etc).**	Previous/Maiden Name

Street Address	City	State	Zip Code
Birthdate (MM/DD/YYYY)	Social Security Number	Primary Phone Number	Secondary Phone Number

Gender ☐Male ☐Female	Primary Language (CHECK ONE) ☐English ☐Spanish ☐Other ____________________	Marital Status: ☐ Single ☐Married ☐Divorced ☐Separated ☐Widowed

Employer	Spouse	Spouse Primary Phone Number	Spouse Secondary Phone Number

PHYSICIAN INFORMATION

Primary Care Physician Name Did your PCP refer you? ☐Yes ☐No	Referring Physician Name or other Physician to receive report
Street Address	Street Address

City	State	Zip Code	City	State	Zip Code

Would you like a copy of a report from today's procedure to go to both physicians listed above? ☐ Yes ☐ No, only PCP

INSURANCE INFORMATION

Primary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ☐Self ☐Spouse ☐Parent ☐Other:______________
Secondary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ☐Self ☐Spouse ☐Parent ☐Other:______________
Tertiary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ☐Self ☐Spouse ☐Parent ☐Other:______________

If Policy Holder is **NOT** the patient: First and Last Name Gender: ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)

Street Address	City	State	Zip Code

Social Security Number	Primary Phone Number	Employer

CONTACT/RIDE INFORMATION

With whom may we discuss your medical care or billing information?

☐ Patient Only ☐ Name of person with whom we may speak: ____

Ride Contact Name	Relationship to Patient	Primary Phone Number	Secondary Phone Number
Emergency Contact Name	Relationship to Patient	Primary Phone Number	Secondary Phone Number

MIDWEST ENDOSCOPY SERVICES, LLC
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you with the best possible care. Thank you in advance for reading this information; it is critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions.

We are here to assist you in providing information to your Health Insurance Company. Please keep in mind that not all services are a covered benefit in all plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Midwest Endoscopy Services, LLC, is ultimately the patient's responsibility.

If you are scheduled for a colonoscopy: The Facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services and American Medical Association guidelines and is not responsible for determining how your benefits will be paid by your insurance plan. Please keep in mind that **all** charges may not be covered under your screening and health preventive benefits. If you have questions please call us at (402)-504-3846 for a more detailed explanation.

If you have insurance, we will submit charges to your primary and secondary insurance provided we have a copy of your assignment of benefits as well as a copy of your insurance card(s). Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. Patients who fail to provide insurance information are directly responsible for payment of their account.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain one prior to your visit. Contact your Insurance Carrier if you are not sure. If a precertification is required you will need one for both Midwest Endoscopy Services, LLC and the physician providing the service. If a referral is not obtained, your insurance company may deny coverage, which could result in patient responsibility.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems arise, we encourage you to contact our office for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

If you do not have insurance, acceptable financial arrangements will need to be arranged prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 933-0602. Please note a deposit will be required at the time of procedure.

For billing purposes, there could be four (4) separate service components which will be billed separately:

- Midwest Endoscopy Services, LLC: You/your insurance will be billed a facility fee for the use of the Ambulatory Surgery Center in which your procedure is being performed. If you have questions regarding this facility fee, please contact us at (402) 933-0602.
- Physician Fee: Midwest Gastrointestinal Associates, PC. will bill a charge separately to you/your insurance for the physician's professional services that are provided during your procedure. If you have questions regarding your scheduled procedure or the physician's fee, please contact Midwest Gastrointestinal Associates, PC.
- Laboratory and Pathology Fee: If you have blood drawn and/or a biopsy taken you or your insurance will receive a bill from the laboratory or laboratories that process your blood work and/or biopsy.
- Anesthesia Services Fee: Monitored Anesthesia Care (MAC) Will be provided by a Certified Registered Nurse Anesthetist and be billed by Midwest Gastrointestinal Associates, P.C.

Midwest Endoscopy Service, LLC accepts checks, cash, Visa, MasterCard, Discover, American Express and debit cards. Online payments can be made at www.midwestendoscopyservices.com.

AUTHORIZATION

I understand that the physician who is rendering services may have an ownership interest in the above referenced facility. The physician or the physician's representative has given me the option to be treated at another facility, which I have declined. I wish to be treated at Midwest Endoscopy Services, LLC.

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Midwest Endoscopy Services, LLC. I understand the above stated charges and that I am responsible for my balance in full. I understand I am financially responsible to Midwest Endoscopy Services, LLC, for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

Signature ______________________________ Date ____________

At Midwest Endoscopy Services, LLC, patient care, safety & satisfaction are very important to our entire staff. In order to provide the best care possible, we want to partner with you in maintaining your safety & satisfaction. If at any time you, your legal representative and/or surrogate have questions or concerns regarding any aspect of your care, please contact Midwest Endoscopy Services for assistance or clarification.

Patient Rights

Every patient has the right to be treated fairly, with respect, consideration, dignity and as an individual. We assure the rights of all patients coming into the Center are respected without regard to race, gender, color, national origin, disability, age, religious or fraternal organization, or any other factor protected by law.

1. Patients are treated with respect, consideration, dignity and provided safe care by competent personnel without discrimination.
2. Patients are informed of patient rights during the admission process.
3. Patients are provided appropriate privacy.
4. Patient disclosures and records are treated confidentially, except when required by law, and patients are given the opportunity to approve or refuse their release.
5. Patients are free from abuse, neglect and exploitation.
6. Patients are given access to the information contained in his/her medical record within a reasonable time period when requested.
7. Patients are informed both of their right to formulate an Advance Directive at the time of admission and the facility's policy regarding Advanced Directives.
8. Patients are informed in advance about care, treatment and associated risks.
9. Patients are given information necessary to make informed decisions regarding their care and treatment. When it is medically inadvisable to give information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Patients are provided information about treatment alternatives and will be advised of the risks, advantages and disadvantages of each.
11. Patients have the right to refuse care, treatment and services and to be informed of the medical consequences of refusal of care.
12. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
13. Patients have the right to refuse to participate in experimental research
14. Patients have the right to know, in advance, the type and expected cost of treatment.
15. Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.
16. Patients, families, and /or and legal representatives or surrogates have the right to effective communication in a manner they can understand. The Center will take reasonable steps, free of charge to the patient, to provide access to tools and services to provide effective communication. These include, but are not limited to interpreters, large print paperwork and selected transcribed documents.
17. Patients will receive services without discrimination based upon race, color, religion, gender, national origin, or payer. Health clinics are not required to provide uncompensated or free care and treatment unless otherwise required by law.
18. Patients, families, and /or and legal representatives or surrogates have the right to express grievances and suggestions to the organization without discrimination or reprisal and have those complaints and grievances addressed with in a timely manner.

Advance Directive Policy

Due to the nature of procedures and the generally healthy status of patients seen at the Center it is the conscious decision and policy of the Center **not** to withhold lifesaving actions in the event of life threatening emergencies. In accordance with Nebraska HHS Regulation and Licensure 7-006.04, this will serve as notice to the patient, the patient's representative, or surrogate of the policy limiting advance directives. In the event a life-threatening emergency occurs (i.e. respiratory or cardiac arrest), the Center will perform emergency procedures as necessary to stabilize the patient and then transfer the patient and the advance directive documentation, if provided, to an acute health care facility where the attending physician, the patient's representative or surrogate and family can make an informed decision regarding the patient's well-being.

To comply with state law, during the registration process, you will be asked if you have an advance directive. Please bring a copy if you have one. If you do not have an advance directive and would like further information please call us at 402-933-1500. Upon request we will mail information regarding advance directives or will have it available to you at registration.

Physician Ownership Notice

The physician who is rendering services may have an ownership interest in Midwest Endoscopy Services, LLC. During the scheduling process, the physician's representative will give you the option to be treated at alternate facilities. If you wish to be treated at another facility please notify your physician's office.

Please initial:

____ I acknowledge that any pathology specimens obtained during my procedure will be processed and clinically diagnosed by Midwest Gastrointestinal Pathology Department.

____ _______________________

Patient / Responsible Party Signature Date

Patient Label Here

MIDWEST ENDOSCOPY SERVICES, LLC

PATIENT HISTORY FORM

REASON FOR PROCEDURE (CHECK ALL THAT APPLY):

☐ Screening Colonoscopy
☐ Family history of colon cancer
☐ Personal history of colon polyps/cancer
☐ Personal history of Crohn's Disease
☐ Personal history of Ulcerative Colitis
☐ Blood in stool/rectal bleeding
☐ Reflux
☐ Difficulty swallowing
☐ Nausea/Vomiting
☐ Bloating/Gas
☐ Increased appetite
☐ Decreased appetite
☐ Unintentional weight change:
Gained ______ pounds/Lost _______ pounds
Over how much time? ________________________
☐ Other : ____________________________________
☐ Pain: ____
____
☐ Location: __________________________________

Please circle one:

1 2 3 4 5 6 7 8 9 10
Very Mild ⟶ Severe

Onset/Duration: _______________________________
Type of Pain: __________________________________
Triggers: _____________________________________
Relief: _______________________________________

Tobacco Use: ☐ Never ☐ Former ☐ Current
If current: ☐ Daily ☐ Occasionally Amount: ________
Alcohol Use: ☐ Never ☐ Former ☐ Current
If current: ☐ Daily ☐ Occasionally Amount: ________
Caffeine Use: ☐ Yes ☐ No ☐ Rarely

PATIENT MEDICAL HISTORY (CHECK ALL THAT APPLY):

☐ Stroke
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Cholesterol
☐ Diabetes: ☐ Type I ☐ Type II

Please specify

☐ Lung Disease ____________________________________
☐ Kidney Disease___________________________________
☐ Heart Disease ___________________________________
☐ Liver Disease ___________________________________
☐ Thyroid Disease _________________________________
☐ Cancer ____
☐ Seizures Date of last seizure :_____________________
☐ Arthritis ____
☐ Other Diseases __________________________________
____
☐ Other Infections _________________________________
____

☐ Hearing Difficulty: ☐ Right Ear ☐ Left Ear ☐ Both
☐ Vision Difficulty _________________________________
☐ Other: ____
____

Date of last medical examination: ___________________

Prior Anesthesia Problems: ☐ None or please specify:
____
____
____

WOMEN ONLY: Are you currently pregnant? ☐ Yes ☐ No

Allergies & Reactions

____
____
____
____
____

Prior Surgeries– please list

____
____
____
____

Prior Hospitalizations – please list

____
____
____
____

_______________________________ _______________________________
Patient Signature Date

_______________________________ _______________________________
Reviewing Nurse's Signature Date

Patient label

Home Medication List

This list of medications will assist us in preparing you for your procedure.
Following the procedure this list will serve as your new medication list.

Please fill out this form completely and bring this form with you the day of your procedure.

Include all prescriptions, over-the-counter, herbals, & vitamins/supplements.
Your pharmacy or primary physician can help you if needed.

Medication Name	**Dose** (mg,units)	**Frequency**	**Last Dose** (date/time)	MD use only **Continue**	MD use only **Hold**	MD use only **Stop**
				☐	☐ ______days	☐
				☐	☐ ______days	☐
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				☐	☐ ______days	☐

New Medications (following procedure)	**Dose**	**Frequency**	**Special Instructions**

______________________________ **Physician Signature**

______________________________ **Discharge Nurse**

MIDWEST ENDOSCOPY SERVICES, LLC
8901 Indian Hills Drive, Suite 100
Omaha, NE 68114 (402)933-1500

Office use only

☐ No medications taken at home
☐ Incomplete medication list
Reason__________________________________
Medication information obtained from:
☐ Patient ☐ Caregiver ☐ Medication List
☐ Brought Medications from home
__________________________**Admitting Nurse**

Original facility copy ◊ Yellow patient copy
Copies to be sent to referring MD office and Endoscopist office