M.A.G.I.C
Mid-Atlantic G.I. Consultants, P.A.
...Advancing GI care

MAGIC EGD Packet

Documents	Instructions
• Patient Registration	• Complete and Return*
• Pre-Procedure Questionnaire	• Complete and Return*
• Consent for Release of Information	• Sign and Return*
• Missed Appointment/Financial Policy	• Sign and Return*
• Medicare Authorization	• Sign and Return* (Medicare patients only)
• EGD Instructions	• Review at home
• EGD Consent	• Review at home

***Please return above forms**
plus
a copy of your insurance card
to MAGIC via one of the following:

- **Email:** scheduling.magic@gmail.com
- **Fax:** **302-225-2388**
- **Mail:** **Mid-Atlantic GI Consultants**
  537 Stanton-Christiana Rd, Ste. 203
  Newark, DE 19713

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PATIENT REGISTRATION FORM

Name_____Sex_____

Social Security #_____Race_____

Date of Birth_____ Today's date_____

Home Address_____

Primary Care Physician_____

Referring Physician _____

Cardiologist Name _____
Your cell_____ Home _____Work_____
Email_____
With whom can we share your medical information?

1. Name_____Phone_____

2. Name_____ Phone_____

Primary Insurance_____

Group#_____

Member#_____

Secondary Insurance_____

Group#_____

Member#_____

Pharmacy Name_____ Phone number_____

Pre-Procedure Medical Questionnaire

Patient Name: _____ **Date of Birth:** _____

Reason for procedure: _____ _

PROCEDURE: **COLONOSCOPY** **EGD** **FLEXSIG**

Do you have a cardiologist? Who?	☐ Y ☐ N
Have you seen your cardiologist in the last 6 months?	☐ Y ☐ N
Have you been told that you have Aortic Stenosis?	☐ Y ☐ N
Do you have an AICD/defibrillator/shock device in your heart?	☐ Y ☐ N
Do you have stents in your heart?	☐ Y ☐ N
Are you currently having a problem with chest pain?	☐ Y ☐ N
Do you have high blood pressure?	☐ Y ☐ N
Do you have any heart or lung tests scheduled in the near future?	☐ Y ☐ N
Have you been told that you have pulmonary hypertension?	☐ Y ☐ N
Are you on home oxygen?	☐ Y ☐ N
Has a doctor ever told you that your airway is difficult to intubate?	☐ Y ☐ N
Do you have severe TMJ causing difficulty opening your mouth?	☐ Y ☐ N
What is your height?	
What is your weight?	
Are you on Dialysis?	☐ Y ☐ N
Do you have a severe latex allergy which has caused breathing problems or required medical attention?	☐ Y ☐ N
Are you on Blood Thinners?	☐ Y ☐ N
• Anti-platelet medications: such as Plavix (also known as Clopidogrel), Effient, and Brillinta	☐ Y ☐ N
• Anti-coagulant medications: such as Coumadin, Warfarin, Pradaxa, Xarelto, and Eliquis	☐ Y ☐ N
Have you had any type of cancer besides skin?	☐ Y ☐ N
If you have cancer, do you currently have a chemotherapy port?	☐ Y ☐ N
Are you diabetic?	☐ Y ☐ N
If YES, are you on insulin?	☐ Y ☐ N
Have you had surgery on your ABDOMEN?	☐ Y ☐ N
If YES, for what?	
Do you take any prescription medication for anxiety, depression, bipolar disease or psychiatric disorder?	☐ Y ☐ N
Do you have a parent, brother or sister who has had colon cancer?	☐ Y ☐ N
Do you have a parent, brother or sister who has had stomach cancer?	☐ Y ☐ N
Have you had a colonoscopy in the past?	☐ Y ☐ N

If YES, approximately what year?	☐ Y ☐ N
Have you had an endoscopy/EGD in the past? What year?	☐ Y ☐ N
Does food get stuck in your esophagus when you swallow?	☐ Y ☐ N
Do you experience heartburn?	☐ Y ☐ N
If YES, do you take medication for it daily?	☐ Y ☐ N
If you take medication daily for heartburn, does it control your symptom most of the time?	☐ Y ☐ N
Do you experience frequent abdominal pain?	☐ Y ☐ N
Do you experience frequent diarrhea?	☐ Y ☐ N
If YES, have you been having diarrhea for more than 3 months?	☐ Y ☐ N
Do you experience frequent constipation?	☐ Y ☐ N
If YES, have you been having constipation for more than 3 months?	☐ Y ☐ N
Do you ever see blood mixed in with your stool?	☐ Y ☐ N
If Yes, has this happened more than 5 times?	☐ Y ☐ N

CONSENT FOR RELEASE OF INFORMATION, FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby authorize *Mid-Atlantic G.I.Consultants, P.A.* to use and/or disclose my heath information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment, and health care operations Specifically, I authorize the release of my medical information to my insurance company or companies. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians of *Mid-Atlantic G.I.Consultants, P.A.* can refuse to treat me.

I have been informed that *Mid-Atlantic G.I. Consultants, P.A.* has prepared a "Notice of Privacy Policies" pamphlet which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I will be offered a copy of this pamphlet and will have the right to review it prior to signing this consent.

I understand that I may revoke this consent at any time by notifying *Mid-Atlantic G.I. Consultants, P.A.* IN WRITING, but if I revoke my consent, such revocation will not affect any actions that *Mid-Atlantic G.I.Consultants, P.A.* took before receiving my revocation.

I understand that *Mid-At/antic* G.I. *Consultants, P.A.* has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that *Mid-Atlantic GI. Consultants, P.A.* restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations, I understand that *Mid-Atlantic* G.I. *Consultants, P.A.* does not have to agree to such restrictions, but that once such restrictions are agreed to, *Mid-Atlantic G.I. Consultants, P.A.* must adhere to such restrictions.

I REQUEST THAT PAYMENTS ISSUED FROM MY INSURANCE COMPANY, OR COMPANIES, BE MADE TO: *Mid-Atlantic G.I. Consultants, P.A.*

_____

Signature of patient or representative **Date**

_____

Print name of patient or representative

FINANCIAL and MISSED APPOINTMENT POLICY

MISSED APPOINTMENTS

If you are unable to keep an appointment for a **procedure** such as **EGD or COLONOSCOPY**, you must notify the MAGIC office at 302-225-2380, option #2 or leave message at Ext. 351 AT LEAST **4 BUSINESS DAYS** prior to the date your procedure was scheduled in order to avoid a ***$100 charge*** for the reserved but unused time on the schedule. Please realize that when you schedule a procedure, you are reserving a procedure room, your GI doctor's time, anesthesia time, nursing and staff time and that time will likely go unused if you do not keep your appointment. It is almost impossible for us to fill your reserved time without 4 days' notice because another patient that might be interested in your spot needs time to make arrangements to take off work, accomplish the bowel prep and find transportation.
If you are unable to keep an appointment for an **office visit**, you must notify the MAGIC office at 302-225-2380 Ext. 361 at least **1 BUSINESS DAY** prior to the date your procedure was scheduled in order to avoid a ***$25 charge*** for the reserved appointment time.

INSURANCE

MAGIC participates with many insurance companies (visit www.midatlanticgi.com). It is YOUR responsibility to determine whether or not our practice is in network with your insurance company. IF WE DO PARTICIPATE with your insurance company, all services performed in our office, at our endoscopy center (Mid-Atlantic Endoscopy Center) or at a hospital will be submitted to the insurance company unless we have received prior notification of non-covered services.

All co-pays and deductibles are the patient's responsibility and will be billed to you by MAGIC. HMO insurances may require referrals for services. If you have HMO insurance, it is YOUR responsibility to obtain the referral prior to the time of service. If you do not have a referral, you will need to reschedule the appointment or pay in full for the service at the time of the appointment.

IF WE DO NOT PARTICIPATE with your insurance company, we will not bill your insurance company. In this case YOU will be responsible for paying your MAGIC bill in full. After paying MAGIC, you may submit your itemized bill to your insurance company for partial or full reimbursement, according to the agreement that you have with your insurance company for out of network services. Please note that MAGIC may charge more than what your insurance company will pay.

PAYMENT METHODS

MAGIC accepts VISA, MASTERCARD, AMERICAN EXPRESS, cash, check, or money order. All payments must be made at the time of service and any outstanding balance is due within 30 days, unless a prior payment arrangement has been made with the billing department. All balances that are unpaid after 90 days will be sent to a collection agency. In this event, you will be financially responsible for all collection and legal fees that MAGIC incurs related to the outstanding delinquent balance. If you have a past due balance, you must pay that in full prior to any upcoming appointment. In addition, you will be required to pay in full at the time of service for any future services.

AGREEMENT

I have read and fully understand and agree to the financial and missed appointment policies outlined above by MAGIC. I also understand and agree that the terms of the above policies may be amended by the practice at any time without prior notification to the patient.

Signature_____Date_____

MEDICARE AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

NAME_____

MEDICARE NUMBER_____

I request that payment of Authorized Medicare benefits be made on my behalf to Mid-Atlantic GI Consultants, P.A. (MAGIC) for any services rendered to me by MAGIC. I authorize any holder of medical information about me to release my information to the Health Care Financing Administration and its agents in order to determine my benefits that are payable for services by MAGIC.

I understand that my signature requests that payment(s) be made to MAGIC and authorizes release of my medical information which is necessary to pay the claim (s). If other health insurance is indicated on the HCFA 1500 Claim Form or on an electronically submitted claim, my signature authorizes release of information to the insurer or agency shown.

In Medicare-assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I understand that I am responsible for the deductible, co-insurance and non-covered services. The co-insurance and deductible are based upon the charge determination for the Medicare carrier.

Signature of patient or patient's representative Date

Mid-Atlantic Endoscopy Center
Consent for Esophagogastroduodenoscopy (EGD)

I hereby authorize Dr. _____and his/her assistants to perform my EGD.

A. I understand that an EGD procedure requires my gastroenterologist to insert a lighted scope into my mouth, then into the esophagus, stomach and duodenum which is the first segment of the small intestine.
B. I understand that, during the procedure my doctor may find it necessary to perform an intervention(s) including but not limited to the following:
    - Tissue biopsy and/or polyp (or other growth) removal
    - Esophageal or stomach dilation
    - Tissue cauterization to stop bleeding
    - Injection of medication into my esophagus or stomach to relax a sphincter or to stop bleeding
    - Injection of ink or stain to tattoo an area that may be abnormal
C. I understand that, if I have a biopsy, my tissue may be sent to a pathologist for analysis and I consent to the retention or disposal of such tissue.
D. I understand that complications may occur during the procedure even though the procedure is done absolutely properly by an experienced gastroenterologist. Furthermore, I understand that although it is impossible for my physician to inform me of every possible complication, the serious complications include, but are not limited to the following:
    - Perforation of the esophagus, possibly resulting in hospitalization and surgery
    - Aspiration pneumonia resulting from the movement of stomach contents backwards into the mouth and then down into the lung
    - Infection, phlebitis, and/or nerve injury related to the IV catheter or IV medications administered
    - Bleeding requiring transfusion or hospitalization
    - Heart or lung problems related to anesthesia
    - Dental injury from a scope instrument
    - Death related to a complication of the procedure

E. I understand that my physician may request the presence and assistance of another doctor, should such assistance be considered necessary for my care. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, to be in attendance during my procedure if the situation arises.
F. I understand that, should a member of the staff become exposed to my body fluid, I will consent to having my blood tested for HIV and Hepatitis.

G. I understand the Mid-Atlantic Endoscopy Center's policy regarding Advance Directives i.e. how my care will be managed should I become unable to relay my requests.
H. I understand the surgical and/or diagnostic procedures performed on me at the Center will be done on an outpatient basis and the Center does not provide 24 hour patient care. If my attending practitioner or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Center to another healthcare facility, I consent and authorize the employees of the Center to arrange for and effect the transfer.
I. I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist, and the like are independent contractors with me and not employees of the Center.
J. Anesthesia services are being provided by First State Anesthesia and I will sign a separate consent for those services.

Certification of Patient and Witness:

I understand and accept all aspects of the written material in this consent form, have been given opportunity to ask questions, and wish to proceed with an EGD examination.

Patient/Legal Guardian signature:_____ Date/time:_____

Witness signature: _____ Date/time:_____

Gastroenterologist's Certification:
I certify that I have explained the EGD procedure to my patient, along with alternatives to the procedure, including doing no test. Physician

Signature:_____Date/time:_____

EGD (Esophagogastroduodenoscopy) Instructions

Please read well in advance of your procedure

1. Diet restrictions:

- 0-6 hours prior to your arrival: NOTHING at all by mouth. No food, drink, candy, gum, mints. If you must take a medication, take it with a SMALL sip of water.
- 6-8 hours prior to your arrival: No food, milk products or juice with pulp. You may have any kind of soda, black coffee or tea with or without sugar or artificial sweetener, water, lemonade without pulp, ice pop, gum, hard candy and medication.
- 8 or more hours prior to your arrival: NO RESTRICTIONS on food or drink

2. Medications:

- You MAY TAKE aspirin and anti-inflammatory medication including ibuprofen, Advil, Motrin, Naprosyn, Voltaren, Aleve, Celebrex and others.
- IF and only if your Cardiologist, Primary Care Physician or other prescribing doctor allows it, you should stop Coumadin, Warafarin, Pradaxa, Xarelto, Eliquis, Plavix, Clopidrel, Effient, or Brillinta before your procedure. The prescribing doctor must indicate the number of days allowed off of the medication prior to the procedure. If the prescribing doctor does not allow you to stop the medication at all, please notify your GI doctor at MAGIC ASAP so that appropriate medical decisions can be made. (Call 302-225-2380 OPTION #2 or leave message at extension 351.)
- With the exception of potent blood thinners, listed above, you may take all medicines on the day of your test and you should take the medication as early in the day as possible. If you must take a medicine within 6 hours of your procedure, swallow only a small sip of water with your pill(s).

3. Driving Restrictions:

- You cannot drive on the day of your procedure, once you have received sedation. You may drive the morning after your procedure. You may take a bus or taxi home ONLY IF you are accompanied by someone who is at least 18 years of age.
- The facility often requires your driver to sit and wait for you throughout the procedure. If your driver cannot stay, your procedure may be cancelled, depending on the facility's policy.

4. Cancellation Policy:

- Your GI doctor, nurse and anesthesia providers have reserved your appointment time just for you. Therefore, you will be charged a $100 cancellation fee if you cancel or reschedule your procedure within 4 business days prior to your appointment.

If you have any questions, please call the MAGIC office at 302-225-2380 OPTION #2 or leave a message at Extension 351