Tucson Gastroenterology Institute

3040 N. Swan Road, Tucson, AZ 85712
Office (520) 547-0645 Fax (520) 795-4492

Informed Consent for Gastrointestinal (GI) Procedure

I authorize Doctor _____ to perform the following procedure: **Esophagogastroduodenoscopy (EGD) with possible biopsy, polypectomy, dilation of narrowed areas, and/or variceal banding.**

The following information is presented to help you understand the reasons for and the possible risks of these procedures.

Explanation of Procedure
Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination.

At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed (polypectomy).

Brief Description of Endoscopic Procedure

- **Esophagogastroduodenoscopy (EGD):** After the administration of sedation, your physician passes a fiber optic instrument through the mouth and back of the throat to allow examination of the esophagus, stomach, and duodenum. Biopsies, polypectomies, dilation, or coagulation by heat of an active bleeding site may be performed if indicated, though all are accompanied by a slightly greater risk of bleeding or perforation.
- **Esophageal Dilation:** After passage of the endoscope, dilating tubes and/or balloons are used to stretch any narrow areas of the esophagus.
- **Pyloric Dilation:** Dilation of the pyloric sphincter (opening from the stomach to the small intestine). After passage of the endoscope dilating balloons are placed through the pyloric sphincter to enlarge the opening.
- **Variceal Banding:** After passage of the endoscope, elastic bands are placed around enlarged veins to obstruct the blood supply.

Monitored Sedation
Monitored sedation involves the injection of an anesthetic agent to reduce or eliminate pain. It is often combined with a sedative to relax and calm the patient.

The desired effects of monitored sedation include: Protective reflexes remain intact (i.e. the ability to blink, cough, or swallow), cooperation, relaxation, easy arousal from sleep, and minimal vital sign and oxygen saturation variation. The undesired effects of monitored sedation include: unarousable sleep, hypotension, agitation, combativeness, respiratory depression/apnea, and loss of protective reflexes.

Principal Risks and Complications of Gastrointestinal Endoscopy
Gastrointestinal endoscopy is generally a low risk procedure. However, all of the complications listed below are possible. Your physician will discuss their frequency with you if you desire, with particular reference to your own indications for gastrointestinal endoscopy. **PLEASE ASK YOUR PHYSICIAN FOR CLARIFICATION OF ANY UNANSWERED QUESTIONS PRIOR TO YOUR TEST.**

1. **Perforation:** Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.

2. **Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy, or dilatation,or variceal banding. Management of this complication may consist of careful observation, blood transfusions, or possibly a surgical procedure.

3. **Chest Discomfort:** Mild retro-sternal pain/tightness and transient painful swallowing may occur following variceal banding. Most of these complications are self-limiting with no need for further treatment.

4. **Medication Phlebitis:** Medications used for sedation may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist for several weeks to several months.
5.
6. **Other Risks:** Includes damage to dental work, particularly loose caps or teeth, drug reactions and complications from other diseases you may already have. Cardiopulmonary arrest and death are extremely rare, but remain remote possibilities. You must inform your physician of all of your allergic tendencies, present medications, and health problems. Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result.

Alternatives to Gastrointestinal Endoscopy
Other diagnostic or therapeutic procedures such as medical treatment, x-ray, and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these issues with you.

Emergency Care
If any emergency should arise calling for additional procedures, operations, or medications, I authorize my physician and his/her designees to do whatever they deem advisable in my best interest. I authorize transfer to a hospital for in-patient care (including anesthesia and blood transfusions), if warranted by my condition.

I certify that I understand the information regarding monitored sedation procedures and that I have been fully informed of the risks and possible complications of my procedure. I hereby authorize and permit my physician and whomever he/she may designate as his/her assistant to perform upon me the above noted procedure. I consent to the taking of photographs during my procedure.

I acknowledge that I am not to drive a motor vehicle before tomorrow, that I will not consume any alcoholic beverages today, that I will avoid making critical decisions or signing legal documents until tomorrow, that no guarantees or warranties have been made concerning my procedure, and that I have had an opportunity to discuss the issues noted above with my physician and to have my questions answered.

_____
Patient Name (please print)

_____ _____
Patient Signature Date/Time Nurse Signature Date/Time

Patient Information

Appointments

We require a photo ID, and a copy of your current insurance card upon check in at each visit to our office. If you need to cancel or reschedule your appointment, we require adequate notice. We require a 24-hour notice of cancellation or reschedule for office visits and 48-hour notice of cancellation or reschedule for procedure appointments. I understand if I fail to give this notice I will be charged a fee of $25 for office visits and $100 for procedures.

Patient Payment Policy

We recommend you contact your insurance carrier regarding these charges prior to any services being rendered as it is the responsibility of the patient to obtain coverage and benefit information from their insurance carrier. Any insurance verification we may provide is done so as a courtesy and is not a guarantee of benefits, payment, or your financial liability.

Your financial liability can include deductibles, co-insurance and/or co-payment as determined by your insurance carrier. Copayments are collected at the time of service. If you do not have your payment, your visit will need to be rescheduled.

PHYSICIAN FEE – Tucson Gastroenterology Specialists, PC

The physician's professional fee is for performing the endoscopy procedure, supervising, interpreting, and consulting with you and your referring physician. Any bill for these services will be submitted under your physician's name. For questions regarding the Physician fee billing, please contact our billing office at (520) 382-1145.

FACILITY FEE – Tucson Gastroenterology Institute, LLC

Tucson Gastroenterology Institute (TGI) or Tucson Medical Center will represent the facility component of your services. Facility fees cover the cost of providing the technicians, nurses, equipment, and supplies. For any questions regarding the facility fee billing for TGI, please contact our billing office at (520) 382-1145. Tucson Medical Center (520) 324-1310.

PATHOLOGY FEE

If biopsies are taken during your procedure, you will be billed by the pathologist reviewing the tissue. If you have any questions regarding your pathology bill, please contact Inform Diagnostics Billing: (888) 344-1160.

Self- Pay

Please call our billing office for the Self Pay fee schedule. If you do not have your payment at the time of service your visit will have to be rescheduled.

Phone Calls

Phone calls are returned in a timely manner within 24-48 hours.

Procedure Arrival Time

Please arrive 30 minutes before your procedure and ensure you have a ride for after your procedure. You will not be able to drive yourself.

Prescription Refills

Please call your pharmacy at least 3 business days before you need your medication refill.

Test Results

Please allow up to 14 days to receive your test results.

Patient Only Policy- Covid-19 Efforts

At this time, we are only allowing the patient in the building due to Covid-19 precautions.

We appreciate your trust in our doctors and look forward to caring for you.

I acknowledge receipt of this information.

_____

Printed Name

_____ _____

Signature Date

Tucson Gastroenterology Specialists, PC
3040 N. Swan Road, Suite B. • Tucson, Arizona 85712
Phone (520) 327-3454 • Fax (520) 327-3431
Please visit us at www.tucsongastro.com

Financial Disclosure

The total cost of medical services at Tucson Gastroenterology Institute is comprised of the following three fees:

- The Endoscopy Center's fee, the Physician's fee and the Pathologist's fee. Each fee is billed separately by the provider of the service.
    - The Endoscopy Center's fee covers the cost of providing the technicians, nurses, equipment, and supplies involved in the performance of your procedure.
    - The physician's professional service fee is for performing the procedure, supervising, interpreting and consulting with you and your referring physician.
    - If there are biopsies taken during your procedure, you will be billed by the pathologist reviewing the tissue. If you have any questions regarding your pathology bill, please contact them directly. If you do not have any specimens sent to pathology you will not be billed for the pathology fee
- TUCSON GASTROENTEROLOGY INSTITUTE is owned by John J. McNerney, MD.

Advanced Directives

The State of Arizona regulations require that your medical chart contain the following information.

Please complete this information and acknowledge your response by signing below.

_____ I have a Living Will _____
(Where is your living will located?)

_____ I have a Medical Power of Attorney _____
(Name of your medical power of attorney)

_____ I have designated a "surrogate" Agent _____
(Name of your surrogate agent)

_____ I have none of the above and do not wish to complete one at this time.

Patient Name:_____ Date of Birth:_____
Please Print

Patient Signature:_____ Date:_____

Please note: If you, as a patient of Tucson Gastroenterology Institute, experience a life threatening emergency while at the center, it is our policy to resuscitate and maintain life until an appropriate and timely transfer can be made to the nearest hospital. This policy is in place regardless of any of the above stated arrangements.

Insurance Authorization and Financial Responsibility Disclosure

By signing below, I authorize Tucson Gastroenterology Institute to release any medical information necessary to process mine or my dependents insurance claim. I authorize any benefits due to be paid directly to Tucson Gastroenterology institute.

Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services. The "estimate" is not a guarantee of benefits. I understand that I may be required to provide a referral/authorization from my primary care provider if needed by my insurance. I also understand that I may also be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance. In the event that my insurance does not pay for services, I agree that I am responsible for payment balances.

I understand that all fees shall be paid at the time of service. Unsettled balances will be referred to an outside collection agency. Returned checks will be subject to additional fees.

Patient/ Guarantor Signature _____

Date _____

Tucson Gastroenterology Specialists, P.C.
3040 N. Swan Road. Suite B. Tucson, AZ 85712
(520) 327-3454
Please visit us at: www.tucsongastro.com

A Patient's Bill of Rights

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizations structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. **The patient** has the right to be treated with dignity, respect and consideration. Our patients will not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis or source of payment.
2. **The patient** has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms and in a language or manner the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient the information should be made available to an appropriate person on his/her behalf. He/she has the right to know by name the physician responsible for coordinating his/her care.
3. **The patient** has the right to participate in decisions involved in his/her care and to receive from his/her physician information to give informed consent prior to the start of any procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. The patient will be informed of alternatives to the proposed procedure and the associated risks and possible complications of the proposed procedure. The patient has the right to know the name of the person responsible for the procedure and/or treatment.
4. **The patient** will receive treatment that supports and respects their individuality, choices, strengths and abilities.
5. **The patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medial consequences of his/her action. The patient has the right to withdraw consent to treatment before treatment is initiated.
6. **The patient** has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, treatment and attention to personal needs are confidential and should be conducted discretely. Those not directly involved in his/her care must have permission of the patient to be present.
7. **The patient** has the right to expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient. The patient has the right to review, upon written request, their own medical record.
8. **The patient** has the right to expect that within its capacity, this ambulatory surgery facility must provide evaluation, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
9. **The patient** has the right to be informed of facility policy on health care directives.
10. **The patient** has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.
11. **The patient** has the right to be advised if this ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
12. **The patient** must consent prior to having photographs taken.
13. **The patient** has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
14. **The patient** has the right to examine and receive an explanation of his/her bill regardless of the source of payment and to be informed regarding the fees for procedures performed at the Center. The patient has a right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.
15. **The patient** has the right to know what facility rules and regulation apply to his/her conduct as a patient.
16. **The patient** has the right to request information about the grievance process at the Center. If a patient has a grievance with the Center, he/she has the right to speak immediately with the Nursing Director or the substitute person assigned to answer to grievances. A formal written grievance may be completed for further review of the grievance.
17. **The patient** has the right to be free from chemical, physical and psychological abuse or neglect. This facility shall ensure that the patient is not subjected to the intentional infliction of physical, mental or emotional pain unrelated to the patient's condition. This facility shall also ensure that the patient is not subjected to any exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, restraint, if not necessary to prevent imminent harm to self or others, retaliation for the submission of any complaint or the misappropriation of personal/private property by the facility's medical staff, personnel members, employees, volunteers or students.
18. **The patient** has the right to timely and appropriate pain management.
19. **The patient** has the right to receive assistance from a family member, representative or other individual in understanding, protecting or exercising the patient's rights.

Patient name:_____ Date of birth:_____

Please print

Patient signature:_____ Date:_____

Patient Responsibilities

It is the patient's responsibility to:

1. Fully participate in decisions involving his/her own healthcare and to accept the consequences of these decisions if complications occur.
2. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and allergies or sensitivities.
3. Provide a responsible adult to transport him/her home from the facility.
4. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
5. Accept personal financial responsibility for any charges not covered by his/her insurance.
6. Be respectful of all health care providers and staff, as well as other patients.
7. Follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary.

For Medicare Beneficiaries, complaints may be reported to the Office of Medicare Ombudsman at:

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Complaints may also be reported to:

Arizona Department of Health Services, Assistant Director, Division of Licensing Services at 150 N. 18th Avenue, 4th Floor Phoenix, AZ 85007, 602-364-2536

Patient Name:_____ Date of Birth:_____
Please Print

Patient Signature:_____ Date:_____

TGI COVID-19 INFORMED CONSENT TO TREAT

PATIENT NAME: _____

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

I understand that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19 which include a robust screening process for all individuals who enter the building, social distancing, requiring the wearing of face masks and enhanced cleaning protocols.

To proceed with receiving care, I confirm and understand the following (Initial in all four places provided) **Initial Below**

- I understand that I am opting for an elective treatment that may not be urgent and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. ☐
- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. ☐
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: ☐
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell
- I have been offered a copy of this consent form. ☐

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____