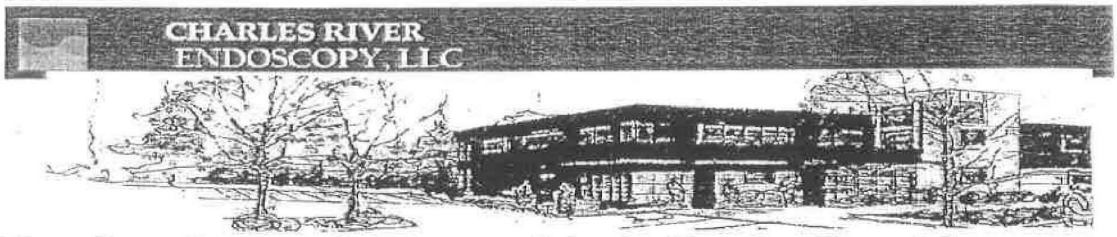
CHARLES RIVER
ENDOSCOPY, LLC

Welcome to Charles River Endoscopy, LLC.
Please read all instructions prior to your procedure.
There will be a $100.00 charge if you cancel your procedure within 72hrs. All double procedures will be $200.00.
(payable to Charles River Endoscopy, LLC)

- On the day of procedure bring your photo ID, insurance card, and 3 completed pages of personal information included in the packet sent from GastroHealth.
- No solid food on the day before your colonoscopy.
- Only clear liquids the day of your procedure
  - No broth or Jello on day of procedure
  - If you take a GLP-1 for diabetes or weight loss no solid food day before procedure or it will be cancelled. If you use Phentermine you must be off that medication for one week prior to procedure.
- Absolutely nothing to drink for 4 hours prior to procedure. This may cause a **cancellation** of your procedure.
- Your ride MUST be here to pick you up within one hour of the scheduled procedure time. **No exceptions.**
  - For all 7:30, 8:00, 2:00, and 2:30 appointments; the ride must wait in our waiting room.
- For your safety, **NO** Ubers, taxis, medical ride share allowed. It is illegal to drive on your procedure day. Your ride must be at least 18 years old.
- Please bring your cell phone and wear your glasses, no contacts.
- Please leave all other valuables at home. The facility is not responsible for lost or missing items.
- If you are not able to understand, read or write English, please bring an interpreter.
- If you have a cough, cold, fever, or COVID call ahead to reschedule.

Please note that each procedure is unique and individualized based on the findings for each patient. Our goal is to always stay on time but please understand that at times unforeseen situations can affect our schedule. In this event, we may call you to instruct you to come at a different time.

Charles River Endoscopy Center * 571 Union Avenue Suite 201 (2nd Floor), Framingham MA 508-665-4111
is a freestanding ambulatory surgery center dedicated to Gastrointestinal Endoscopy. Patient satisfaction is our main goal. Our facility was chosen with quality, safety, patient privacy, and convenience in mind. Charles River Endoscopy Center is a member of the American Association of Ambulatory Surgery Centers (AAAHC). We do accept most insurance plans.



Absolutely nothing to drink (including the prep/ water, etc.) for 4 hours prior to your procedure. This WILL cause a cancellation or delay of your procedure

Your ride must be available within 30 minutes of your arrival to recovery and will be called (if requested) at that time. Your typical stay will be 1-2 hours.

Your TEST WILL BE CANCELED if you do not have an AVAILABLE RIDE.

Clinic hours close at *330pm*.

Your ride must be over 18 and they are expected to come up to the unit to escort you safely home due to the anesthesia you will be getting. **For your safety you may NOT DRIVE YOURSELF HOME OR TAKE A CAB/ UBER after the procedure. We want you to be safe! It is illegal for you to drive, use machinery or sign legal papers on the day of your test. The medicine that you will receive makes you sleepy and slower to respond.**

Please leave all jewelry, contact lenses, phones or any valuables at home/ with your ride. The facility is not responsible for lost or missing items.

If you are not able to understand, read or write English, please bring an interpreter.

Please note that each procedure is unique and individualized based on the findings for each patient. Our goal is to always stay on time but please understand that at times unforeseen situations can affect our schedule. In this event, we may call you to instruct you to come at a different time.

In order to expedite admission and help us to stay on time, please have the attached 3 pages completed before arrival for every procedure you have with us to ensure we are aware of any changes in your health history. We need an updated history each time to ensure your safety during anesthesia. Also, for every procedure, please have available your photo ID and insurance card at check in to ensure we can verify who you are and that we have the correct information to bill your insurance. Our unit is separate from the doctors so we will not have access to the same information that you presented at the gastroenterology office.

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DIRECTIONS TO CHARLES RIVER ENDOSCOPY (South Entrance- Second Floor)

From Points North:
From Route 9, take Edgell Road/ Main St. exit south towards downtown Framingham.
****From lights at Route 9 exit ramp, stay on Union Avenue. (slight left at light at Franklin, straight through traffic circle at Maple/ Main) until just past Neville Rd. Look for 571 Union Avenue on left.*

From Points South:
Route 495 N to Exit 22 Interstate 90 East/ Mass Pike (toll road). Take Mass Pike exit 12 to Route 9 East/ Worcester Road towards Framingham. Follow directions "From Points North" beginning with asterisk.

From Points West:
Route 9 East, Follow directions "From Points North" beginning with asterisk.

From Points East:
Interstate 90 West/ Mass Pike (toll road). Take Mass Pike exit 12 to Route 9 East/ Worcester Road towards Framingham. Follow directions "From Points North" beginning with asterisk.

CHARLES RIVER ENDOSCOPY, LLC

YOUR DRIVER SHOULD REMAIN READILY AVAILABLE FOR TRANSPORT WHILE YOU ARE AT OUR CENTER. THEY ARE WELCOME TO REMAIN IN THE WAITING ROOM IF THEY PREFER.

Absolutely nothing to drink (clear liquids &/or prep) for 4 hours prior to the procedure as this will delay your procedure

Please discuss any medications that you take with your Prescribing Doctor and Gastroenterology doctor before discontinuing

Please fill out these three forms at home and bring with you on the day of your visit. You must also bring a form of identification & your insurance card(s) each time you visit our clinic. Thank you.

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: M / F

Date of birth: ___/___/_____ Age: ____ *Married Single Widowed* (circle) Height: ____ Weight: _____lbs.

Home Phone: (_____) _____ Cell Phone: (_____) _____

Please put an asterisk next to the preferred phone number to call you when doing a follow up call.

Address: _____ Town & Zip Code: _____

Email Address: _____ Ethnicity: _____ Language: _____

Do you need a translator (circle) Yes/ No Type: *Language / Speech / Hearing / Written Material* (circle)

Ride Home: _____ Phone: (____) _____ Phone: (____) _____

(Please provide a phone number even if your ride plans to stay. Your ride must be over 18 and present within a half hour of discharge/ no taxi car service can be used without a responsible adult to accompany you)

Have you been to Charles River Endoscopy before? Yes or No
If so please write date of last procedure: _____

AUTHORIZATION AND CONSENT FOR GENERAL TREATMENT AND BILLING

1. I wish to be treated at Charles River Endoscopy LLC. While in the center, I permit my doctor, Charles River Endoscopy LLC, and its employees and all other persons caring for me to treat me in the ways that they judge beneficial to me. I understand that this care may include tests, examinations, photography, the administration of medication and medical treatment.
2. I authorize Charles River Endoscopy LLC to furnish information and/or photocopies of my medical record for this treatment which record may or may not contain privileged information, to an insurer, compensation carrier, social security administration or welfare agency which may be providing financial assistance for my hospital care.
3. I hereby authorize payment directly to Charles River Endoscopy LLC of any group benefits, private policy benefits, and major medical benefits as determined by the insurance company or Medicare benefits. I also authorize payment directly to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for treatment rendered, but not to exceed regular charges for the service. I understand that I am responsible for the hospital and physician(s) charges not covered by this visit.
4. I permit a copy of this authorization to be used in place of the original.
5. I have received a copy of Charles River Endoscopy LLC's Notice of Privacy Practices/ HIPPA.
6. I authorize payment of Medigap Benefits to Charles River Endoscopy LLC for services provided.

X _____ _____ _____

Patient's Signature Date Time

If applicable: The patient is unable to sign due to _____

I therefore, consent for the patient (print name) _____

X _____

Signature of Patient Representative *Relationship* *Date* *Time*

Print name of Representative _____ ID _____

_____

Witness *Date* *Time* *Print Name of Witness*

_____

Witness *Date* *Time* *Print Name of Witness*

CHARLES RIVER ENDOSCOPY, LLC

PLEASE CIRCLE THE SPECIFIC ITEM YOU ARE ANSWERING "YES" TO IN ORDER TO MAKE IT VERY CLEAR TO OUR HEALTH CARE PROVIDERS

Pre-Procedure Medical Form

Name: _____

Procedure: _____

Reason for Procedure: _____

_____

Doctor: _____

Yes No

- ☐ ☐ Immune problems: Type: _____
- ☐ ☐ Any type of cancer: Type: _____
- ☐ ☐ Do you have any difficulty walking up a flight of stairs?

Cardiac Problems:

Yes No

- ☐ ☐ High Blood Pressure
- ☐ ☐ Valve Replacement; Date of surgery: _____
- ☐ ☐ Heart Murmur/Palpitations/ Arrhythmias
- ☐ ☐ Chest pain/Heart Attack; Date: _____
- ☐ ☐ Pacemaker; Date of placement: _____
  Last Date Tested: _____
- ☐ ☐ Pacemaker with a Defibrillator
- ☐ ☐ Bypass or angioplasty; Date of surgery: _____
- ☐ ☐ Swelling of Extremities
- ☐ ☐ Irregular heart rate/ Atrial Fibrillation (Afib)
- ☐ ☐ Have you ever had a stress test?
- ☐ ☐ Other: _____

Respiratory Problems:

Yes No

- ☐ ☐ Asthma/ COPD/ Emphysema
- ☐ ☐ Sleep Apnea; Type of device: _____
- ☐ ☐ Do you snore?
- ☐ ☐ Tuberculosis
- ☐ ☐ Smoke (now/ past); Amount: _____
- ☐ ☐ Other: _____

Liver/Gallbladder Problems:

Yes No

- ☐ ☐ Hepatitis: A B C
- ☐ ☐ Cirrhosis/Liver Disease
- ☐ ☐ Gallbladder Disease/Surgery
- ☐ ☐ Recreational Drug Use; Type: _____
- ☐ ☐ Alcohol Use; Amount: _____
- ☐ ☐ Other: _____

Neurological Problems

Yes No

- ☐ ☐ Stroke
- ☐ ☐ Seizure
- ☐ ☐ Headache
- ☐ ☐ Dizziness
- ☐ ☐ TIA
- ☐ ☐ Active shingles
- ☐ ☐ Glaucoma

Blood Disorders:

Yes No

- ☐ ☐ Anemia
- ☐ ☐ Clotting / Bleeding disorders
- ☐ ☐ Bruising
- ☐ ☐ Active MRSA infection
- ☐ ☐ HIV/ AIDS
- ☐ ☐ Other: _____

Endocrine Problems:

Yes No

- ☐ ☐ Thyroid problems
- ☐ ☐ Diabetes Insulin__ Oral__ Diet controlled__

Orthopedic Problems:

Yes No

- ☐ ☐ Limitation of movement; Where: _____
- ☐ ☐ Joint Replacement _____
- ☐ ☐ Metal pins, rods, plates: _____
- ☐ ☐ Body piercings _____

Psychiatric:

Yes No

- ☐ ☐ Depression/ Anxiety/ Panic Disorders
- ☐ ☐ Confusion/ Developmental Delays
- ☐ ☐ Bipolar/ Schizophrenia
- ☐ ☐ Other: _____

Kidney/Prostate Problems

Yes No

- ☐ ☐ Kidney Failure/ Kidney Stones
- ☐ ☐ Urinary Incontinence

Men Only:

- ☐ ☐ Prostate Enlargement
- ☐ ☐ Prostate Cancer
- ☐ ☐ Other: _____

Women Only:

Yes No

- ☐ ☐ Hysterectomy
- ☐ ☐ Mastectomy/Lumpectomy R L
- ☐ ☐ Are you pregnant? Y___ N___ N/A ___
  Date of last menstrual period: _____

GI Problems:

Yes No

- ☐ ☐ Family History of Colon Cancer

Relationship: _____

- ☐ ☐ Personal History of Colon Cancer
- ☐ ☐ Family History of Colon Polyps

Relationship: _____

- ☐ ☐ Personal History of Colon Polyps
- ☐ ☐ Diverticulosis/Diverticulitis
- ☐ ☐ Colitis/Crohns
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Bleeding/ Hemorrhoids
- ☐ ☐ Constipation/Diarrhea
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Barrett's Disease
- ☐ ☐ Esophageal Strictures/Choking
- ☐ ☐ Acid Reflux
- ☐ ☐ Cdiff
- ☐ ☐ Trouble swallowing/ food sticking
- ☐ ☐ Weight Loss/Nausea/Vomiting

CHARLES RIVER ENDOSCOPY, LLC

Pre-Procedure Medical Form

Name: _____ Height: _____ Weight: _____

Primary Care Physician:

Name first and last name: _____

Location: _____

Pharmacy Info:

Name: _____

Location: _____

Please list any other Medical/Surgical History/ hospitalizations or other problems/ concerns that you have:

_____

_____

_____

Any relevant family history: _____

Yes No Have you or any family members ever have any problems with anesthesia in the past? Type: _____
Yes No May we leave a message on your home/cell answering machine regarding your care?
Yes No Can we discuss the procedure with anyone other than you (i.e. your ride, primary care, family etc.)

Do you use (circle that apply): eyeglasses contacts hearing aids dentures

Yes No **Latex Allergy/ Egg/ Soy/ Nut?** (please circle any that apply) & **Reaction:** _____

Medication Allergy (if present, please list the reaction)? _____

Other Allergy (if present, please list the reaction)? _____

Please List ALL Current Medications/Vitamins (*Prescriptions AND Over the Counter*)

Medication	Dose	Frequency	Last Dose (*Important*)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Signature: _____ Date: _____

Nurses Signature: _____ Date: _____

This information has been reviewed and updated with the patient prior to the procedure.

Copy of Bill of Rights, Informed Consent & Privacy Policy given to patient to review prior to procedure. ☐