GASTROINTESTINAL ASSOCIATES, Inc.

1095 Rydal Rd, Suite 100
Jenkintown, PA 19046
PH: 267.620.1100
www.gastropa.com

ENDOSCOPY-COLONOSCOPY PROCEDURE PACKET

Thank you for choosing Gastrointestinal Associates for your digestive health needs. Your physician has recommended a procedure, which has been scheduled for the date and time below. It is imperative that you thoroughly read this packet as well as any prep instructions, and follow the instructions therein. We provide direction on medications, supplements, herbals, and food / liquid intake restrictions which may need to be implemented up to 2 weeks prior to your procedure. Failure to follow these restrictions could mean the cancellation of your procedure. If you have any questions about the instructions, please contact our office.

Patient Name: _____ Arrival Time: _____

Procedure Date: _____ Procedure Time: _____

YOUR PROCEDURE IS SCHEDULED AT:

ABINGTON HOSPITAL
INTERVENTIONAL PROCEDURE UNIT (IPU)
Abington, PA 19001
Report to Radiology/MRI/Horace Avenue Entrance
Arrive 1 hour before procedure time
Valet Parking/Self Pay Garage Available

HOLY REDEEMER HOSPITAL,
Meadowbrook, PA 19046
Report to Same Day Surgery/Third Floor
Arrive 1 hour before procedure time
Valet Parking/Self Pay Garage Available

AMH ENDOSCOPY CENTER,
1235 Old York Road,
Levy Medical Plaza, Suite G23
Abington, PA 19001
Arrive 45 minutes before procedure time
Parking avail in the back of the Levy Medical Plaza

HOLY REDEEMER ASC
821 Huntingdon Pike, Suite 100
Huntingdon Valley, PA 19006
Arrive 1 hour before procedure time
Parking available front and side of building

JEFFERSON LANSDALE HOSPITAL
Same Day Surgery
100 Medical Campus Drive
Lansdale, PA 19446
Report to ground floor of the main entrance
to patient registration
Arrive 1 hour before procedure time
Parking available
You will need to call 215-361-4520 the business
day prior to your procedure between 2PM-4PM

GASTROINTESTINAL ENDOSCOPY CTR (GIEC)
1600 Horizon Drive, Suite 107
Chalfont, PA 18914
Arrive 45 minutes before procedure time
Parking available

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INSTRUCTIONS

Bowel Prep

- Please read the bowel prep and ensure that you understand the instructions. You may need to purchase over-the-counter items or fill a prescription, depending on the prep. Please ensure that you have the prep at least 5 days in advance of your procedure.
- **Medications**: the prep instructions review when certain types of meds must be held prior to your procedure. Please review this section and let your gastroenterologist know if you have any questions. You may also need to discuss with your prescribing physicians to determine if any meds are considered "necessary" be taken on the morning of the procedure.
    - If you have any medication changes prior to the procedure, it is important to let our office know!

Transportation

- You must arrange for an adult driver (over 18) to accompany you to and from the procedure unit. The unit will check that you have a driver and will cancel the procedure if you do not have one. Your driver must wait in the procedure unit waiting room until you are discharged; they may not leave the premises, or your procedure will be cancelled.
- If you are taking a taxi or public transportation, you must have an adult (over 18) with you. You cannot drive for 12 hours following your procedure; therefore, you must have a driver.
- Procedure times are sometimes adjusted a day or two in advance, please ensure your driver is available should your procedure time need to be changed.

Other important items

- On the day of your procedure, please remove all jewelry, including facial / nose piercings, prior to arrival at the procedure unit.
- Let us know of any medication changes prior to your procedure.
- Let us know of any insurance changes prior to your procedure.
- Bring your insurance cards and make sure that your referral (if required) is in order for the doctor's charge and the facility's charge. You are responsible for any copays.

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INSURANCE & REFERRAL INFORMATION

When having a procedure, typically there will be 3 separate charges: one each for the physician, the anesthesiologist, and the facility. If specimens are taken, there may also be a bill from the lab which processes them.

- It is your responsibility to understand the financial responsibility you may have, such as co-pays, co-insurance or deductibles.
- GIA strongly recommends that you contact your insurance carrier to determine what your out-of-pocket expense will be for the procedure. The question to ask is:
    - What will be my total out-of-pocket expense to have my procedure done at this facility. Include the facility tax ID (see reverse) and the name of the procedure. The charge will differ depending on the licensing of the unit where you are scheduled.
    - Additionally, it is important for you to check with your insurance carrier regarding your policy's coverage pertaining to anesthesia.
- Please note the following regarding insurance coverage of screening colonoscopies: If your colonoscopy has been scheduled for screening (meaning you have no symptoms with your bowels*), and your doctor finds a polyp or tissue that has to be removed during the procedure, this colonoscopy is no longer considered a screening procedure; it is considered a surgical procedure and your insurance benefits may change. Please check with your insurance company prior to your procedure date to see what your out-of-pocket costs may be.
- *Symptoms such as change in bowel habits, diarrhea, constipation, bleeding, anemia, etc.

Referrals

- If your insurance requires a referral from your primary doctor, please call for that at least one week prior to your appointment so that your doctor's office has time to process the referral. They may need our practice NPI number. Your primary doctor may require a minimum of 48-72 hours to issue a referral.
- **Aetna** and **Keystone** require two (2) active referrals: 1.) referral made out to Jefferson Community Physicians/ Gastrointestinal Associates with code #99499 (evaluate and treat) or a specific procedure code; and 2.) referral made out to the facility where the procedure is being performed.
- **Cigna** requires a written script from your primary doctor for office visits and/or procedures.
- If your insurance requires that you have a referral, an incorrect referral or no referral may mean that your procedure cannot be performed and will have to be rescheduled.
- Please note a referral is not a requirement of Gastrointestinal Associates, Inc. but of your insurance carrier
- Referrals must be submitted to our office prior to your procedure.
- You are personally responsible for any fees not covered by your insurance and you will be billed by our office.

Billing Questions

If you have questions regarding any bill, it is important that you call the phone number noted on the bill itself. The facility, lab and anesthesiologist are not part of GIA, and we would not be able to assist with these concerns. For questions regarding our physician charges, our billing company may be reached at 267.620.1100, option 6.

PLEASE BE SURE THAT YOU UNDERSTAND YOUR FINANCIAL RESPONSIBILITY PRIOR TO THE PROCEDURE.

IF YOUR INSURANCE CHANGES, YOU MUST INFORM OUR OFFICE IMMEDIATELY.

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PROCEDURE & FACILITY CODES

It is your responsibility to check with your insurance carrier regarding your coverage and your potential financial responsibility.

Gastrointestinal Associates Provider Numbers:
NPI: 1013436542
Tax ID: 232678055

Procedure Codes:

Anoscopy: 46600
Bravo: 91035 and 43235 (both)
Capsule Endoscopy: 91110
Colonoscopy: 45378
Colonoscopy (Screening): G0121
Colonoscopy (High Risk): G0105
Colonoscopy with EMR: 45390
Colonoscopy with EUS: 45391
CT Scan: 76360
Endoscopy: 43235
Endoscopy with EUS: 43259
ERCP: 43260
Flexible Sigmoidoscopy: 45330
Ligation of Hemorrhoid by rubber band: 46221
Liver Biopsy: 47000
Motility: 91010
Paracentesis: 49080
PEG (Feeding Tube): 43246
Proctoscopy: 45300
Remicade: J1745

Procedure Facilities:

Gastrointestinal Endo. Ctr (GIEC)
Fax: 215-997-3282
NPI: 1740785096
Tax ID: 82-208-1770

Holy Redeemer Hospital
Fax: 215-938-2812
NPI: 1750371522
Tax ID: 23-153-4300

Holy Redeemer ASC (821)
Fax: 215-214-0566
NPI: 1467442657
Tax ID: 23-302-0527

Jefferson Abington Hospital
Fax: 215-481-3305
NPI: 1811992084
Tax ID: 23-135-2152

Jefferson Abington Hosp. Endo. Ctr (Levy G23)
Fax# 267-635-1206
NPI: 1811992084
Tax ID: 23-135-2152

Jefferson Lansdale Hosp
NPI: 1386896306
Tax ID: 26-335-9979

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COLONOSCOPY INFORMATION SHEET

This information sheet is provided to help you understand colonoscopy. If you have questions after reading this sheet, please do not hesitate to ask them. Upon your arrival at the facility for your procedure you will be asked to sign a consent form.

WHAT IS COLONOSCOPY?

Colonoscopy is an examination of the large intestine using a flexible tube (colonoscope) with a video camera at the end. The tube is inserted into the rectum and advanced through the colon. At the time of the examination the doctor can take tissue samples (biopsies) or remove abnormal growths such as polyps. Other procedures are sometimes performed such as applying clips or electrocautery to prevent or control bleeding, or injecting fluid or dyes into the bowel wall. Patients usually receive a sedative medication injected through an intravenous line (IV) and are sleepy or asleep throughout the procedure. On average, the procedure takes between 20 minutes and an hour.

WHY IS COLONOSCOPY DONE?

Colonoscopy is done to detect colon cancer or pre-cancerous polyps in both average risk individuals and in those with an increased risk of colon cancer, such as those with a family history of colon cancer or a personal history of inflammatory bowel disease. It is also done as part of the evaluation of symptoms such as rectal bleeding, diarrhea, change in bowel habits, and other conditions.

WHAT IS THE SUCCESS RATE OF COLONOSCOPY?

An examination of the entire colon is possible in most patients. Occasionally a complete examination is not possible because of narrowing of the colon, the presence of an unusually long and twisty colon, or looping and sharp angulation (usually from scarring related to previous surgery or diverticulitis). Even when the entire colon can be reached with the colonoscope, there is a chance that a polyp or other abnormality will not be seen. This chance is higher when pre-colonoscopy cleansing of the colon is not adequate, but still exists even when the colon is well prepared. If the examination is incomplete, you may need additional testing such as barium enema x-ray or CT colonography (“virtual colonoscopy”), or perhaps another colonoscopy.

WHAT ARE THE RISKS OF COLONOSCOPY AND ASSOCIATED PROCEDURES?

Colonoscopy is considered a relatively safe procedure, but serious complications occur in about 1 person out of 1000 (0.1%). These complications include infection, perforation (puncture or tear of the bowel wall creating a hole), bleeding (frequently from a treatment site, such as the place where a polyp was removed), cardiac problems such as heart attack or rhythm disturbances, sedation related complications such as aspiration or decreased respiration, and even death which is quite rare. While a complete listing of possible rare complications would be quite lengthy, this list includes some of the most significant risks.

WHAT ARE THE ALTERNATIVES TO COLONOSCOPY?

There are several other methods which can be used to examine the bowel. These include a limited examination which is confined to the rectum and lowest portion of the colon (flexible sigmoidoscopy), barium enema x-ray, and CT colonography (“virtual colonoscopy”). Examination of the stool for the presence of microscopic amounts of blood can be used as a screening technique for colon cancer.

WHAT CAN I EXPECT AFTER THE PROCEDURE?

You may feel bloated or have cramping for 1-2 hours after the procedure is completed. You may feel tired and need to take a nap once you are back home. It is common to go for a day or two without a bowel movement. If biopsies are done or a polyp is removed, you may see a small amount of bleeding from the rectum. You should plan to eat a light meal after the procedure, and then return to a normal diet if you are feeling fine. You should be completely recovered and able to return to your usual activities by the next day. You cannot drive for a minimum of 12 hours after your sedated procedure.

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PERORAL 'UPPER" ENDOSCOPY INFORMATION SHEET

This information is provided to help you understand peroral endoscopy. If you still have questions after reading this form, please do not hesitate to ask them. Upon your arrival at the facility where you will have your procedure, you will be asked to sign a consent form.

Key Terms

- Peroral Endoscopy: an examination of the esophagus, stomach and duodenum, using a thin flexible scope with a video chip at its end that is swallowed. Various additional procedures may be done at the time of peroral endoscopy. These could include but are not limited to the following:
    - Biopsy: the removal of a small amount of tissue, smaller than a grain of rice, for microscopic examination. It is painless and is done through the scope.
    - Dilatation: the stretching open of a narrowed portion of the digestive tract.
    - Fulguration & Sclerotherapy: methods used to clot blood vessels that can cause problems with bleeding. These methods can also be used to destroy small tumors.

Reason for doing Peroral Endoscopy

- Peroral endoscopy is performed to evaluate the upper digestive system for causes of such problems as abdominal pain, difficulty swallowing, internal bleeding, weight loss or abnormal x-ray findings. Peroral endoscopy is usually more accurate than x-ray examination. Bleeding may be successfully treated during peroral endoscopy.

Likelihood of success

- Peroral endoscopy can usually be accomplished with adequate patient relaxation and if the stomach is empty. Some areas in the stomach and the duodenum are very sharply curved and may not be completely visualized.
- Dilatation is usually successful. Narrowed portions of the digestive tract do however have a tendency to scar down again and dilatation usually has to be periodically repeated.
- Sclerotherapy or cautery to stop severe, life-threatening bleeding is successful in most cases. If the bleeding is coming from a very large blood vessel, it is less likely to work and surgery will usually be required to stop bleeding.

Risks of Peroral Endoscopy and associated procedures

- Peroral endoscopy, biopsy, dilatation and fulguration of small lesions are considered to be relatively safe procedures. About 1 in 1,000 patients will experience a serious complication. To put that number into perspective, your chance of having a fatal automobile accident each year of your life is 1 in 5,000.
- The significant complications most likely to occur from peroral endoscopy and biopsy are perforation or infection of the throat or esophagus (the swallowing tube). Serious cardiac complications can occur, but they are rare. Vomiting and then breathing in some stomach contents may occur occasionally. This may cause pneumonia.
- The risk of fulguration or cautery of bleeding blood vessels or ulcers is higher because patients having these procedures are already very seriously ill. Increased bleeding or perforation can occur because of these problems.
- An irritation of the vein where medication is injected occurs in some patients. On rare occasions, this irritation may last for months but it eventually goes away without causing serious problems.
- Peroral endoscopy can miss ulcers or tumors on occasion. Other complications have been reported but they are extremely rare.
- Bleeding and/or perforation may require surgery.
- If you have capped teeth, fragile teeth or teeth which are in disrepair, there is a potential risk for injury or loss of a tooth or dental apparatus during upper endoscopy.

Alternatives to Peroral Endoscopy

- The alternative to a diagnostic peroral endoscopy is Upper GI X-ray examination. The alternative to dilatation would be either surgery, which is much more risky than dilatation, or living with the difficulties associated with the narrowed portion of the digestive tract.
- The alternatives to sclerotherapy or cautery of bleeding points or to polypectomy would be to do nothing or to operate. Either of these two options is usually more risky than endoscopic treatment.