Text

Description automatically generated**Office Hours**

Monday – Friday 6:30 am - 4:30 pm

Sat – Sun Closed

After Hours or Emergency Please Call 911

Or go to the Emergency Room

1302 Franklin Ave. # 1000

Normal, IL 61761 309-268-3400

**Please provide a copy of your COVID Vaccine Card on the day of your procedure if fully vaccinated.**

*(2 injections -Pfizer or Moderna or 1 injection J&J)*

**No Preoperative Covid 19 Test required regardless of vaccination status.**

|  |  |  |
| --- | --- | --- |
| • | **Previous Covid 19 positive patients must be symptom free for at least 14 days in order to have procedure done at DDEC.** |  |
| • | **If you are not symptom free for at least 14 days, you will need to have your procedure rescheduled.** |
| • | **Your support person MUST be symptom free for at least 14 days or they will not be allowed in the pre/post area or our office.** |

**Please call our office at 309-268-3400 if**

• **You have had close contact with a confirmed Covid 19 patient AND you are displaying any symptoms of Covid 19.**

Graphical user interface, application, website

Description automatically generated

**This list is not all possible symptoms. Please call your healthcare provider**

**for any other symptoms that are severe or concerning to you.**



PATIENT INFORMATION SHEET UPDATED 8/23/2022

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| --- |
| **Medical Office Center I - Carle/BroMenn**  **1302 Franklin Ave. #1000 Normal, IL 61761**  Monday – Friday 6:30 am - 4:30 pm  (309) 268-3400 www.giendo.org      **PATIENT MESSAGING SERVICE – Opt in to Receive TEXT MESSAGES from DDEC**  DDEC offers a convenient HIPAA compliant, mobile phone texting solution to improve patient communication.  **Features Include:**   * **Pre-procedure appointment confirmations-Respond YES to confirm or RS to reschedule** * **Post procedure-Respond YES or NO if follow up call is needed** * **Real time texting with patients** * **Emergency Mass Communication to Patients**         **CHECKING IN FOR YOUR PROCEDURE IS EASY & EFFICENT**  Mobile pre-check is available via email 3 days prior to your procedure. When email is received it allows you to confirm your procedure, demographic information, insurance and driver information. If you haven’t provided your email address please call us at 309-268-3400. This service is optional.    **When you arrive for your procedure- check in at our front desk with the receptionist and provide your driver’s license and insurance card if not completed during mobile pre-check.**  Mobile Pre-Check is **HIPAA compliant** and in full compliance with all privacy rules, regulations and is fully encrypted. The screen does not allow onlookers to view the information unless they are standing directly in front of the kiosk.          **Online Bill Pay Available**  Go to [WWW.PATIENTNOTEBOOK.COM/DIGESTIVE](http://www.patientnotebook.com/DIGESTIVE) enter your account number from your invoice and amount you are paying. There is also an option to have your receipt emailed directly to you. |

**Medical Office Center I - Carle/BroMenn**



**1302 Franklin Ave. #1000 Normal, IL**  **61761**

Monday – Friday 6:30 am - 4:30 pm

(309) 268-3400

www.giendo.org



# Preparation At Home

**Follow procedure-specific instructions provided by your doctor’s office.**

**For Colonoscopy:** Follow your prep from the physicans office. Drink plenty of clear fluids after each prep dose.**Stop all fluids 2 hours before your procedure. This includes no gum, mints, lozenges, cough drops or candy.** If you have not had a bowel movement after the second prep, please call the center as early as possible. **309-268-3400**

*\*Take all of your morning medications with a sip of water after prep has been completed, unless otherwise instructed*.

**For Esophagogastroduodenoscopy – Upper Endoscopy (EGD):**

* 8 hours prior to procedure **stop** all solid food, milk, cream and full liquids (ie: ice cream, yogurt, pudding)

\**You may have clear liquids up to 2 hours prior to procedure*

* 2 hours prior to procedure **stop** all clear liquids
* **Nothing by mouth 2 hours prior to procedure.** **(No mints, gum, lozenges, cough drops or candy)**

**Please DO NOT smoke for at least 24 hours prior to your procedure.** This includes cigarettes, pipes, cigars, ecigarettes, marijuana and other substances. Smoking can cause complications during or after the procedure. **\*Chewing tobacco must be stopped 6 hours prior to procedure.** Failure to comply may result in the cancellation of your procedure.

# What To Bring & What Not To Bring

* Please bring your **Updated** **Insurance card/Medicare card, Photo I.D**.
* Please bring your **Living Will / Power of Attorney for Health Care,** if available.
* **If you have a Neurostimulator, please bring the shut off device with you.**
* Wireless Internet access is available for use in the reception/waiting room. For your privacy: **No audio/video recording or taking of photographic images is allowed.**
* No metal jewelry should be worn. You may wear makeup & light nail polish (avoid dark red).
* Do not wear contact lenses the day of the procedure.
* Lockers are available for personal clothing – please leave valuables at home.

# Medications & Lab Work

Bring a list of current medications (dosage & intervals). Include over the counter & herbal medicine. Bring your inhaler if you have one. Follow your physician’s instructions regarding medications prior to procedure. Any patient taking Coumadin may have a blood test drawn upon admission. Any patient taking Insulin will have a blood test drawn upon admission and postprocedure. Any female who hasn’t had a hysterectomy, tubal ligation or gone through menopause, must provide a *urine sample* on arrival.

# Arrival

Please arrive **45 minutes** prior to scheduled procedure time. Due to schedule changes, you may be called to arrive at a different time.

**For the safety of our patients and staff, DDEC allows ONE SUPPORT PERSON to attend patients in the pre/post room, if desired. The support person must stay in the pre/post room while in the clinical area. A Responsible Adult Must Be Available by Phone at all times.** The responsible adult must drive you home & be available to assist you at home for 24 hours after discharge. **No exceptions.** Taxi cabs, Uber, and Lift may be used only if your responsible adult is riding with you. **City buses are prohibited.**

**Length of Stay**

Length of stay from admission to discharge averages 2 hours.

# Questions

For questions or concerns after hours please call your physicans office to speak with an on call physican. **In the event of an emergency – call 911 or go to the nearest emergency room.** Services provided include GI diagnostic and theraputic endoscopic procedures, for more information call our Center at 309-268-3400.

DIGESTIVE DISEASE ENDOSCOPY CENTER complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Please contact the Center prior to your procedure. Credentials of our healthcare professionals are available upon request by calling 309-268-3400. *Revised 9/15/2022*



Is located in



Medical Office

Cen

ter 1



Free Valet Service

And Handicap



parking available

at Main Entrance



Offic

of Medical

e Center 1



Valet



Patient & Visitor Parking



**Carle BroMenn Medical Center**

**Patient Parking Lot**

# PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

**The Center is an “Ambulatory Surgery Center”.** The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention. Please be aware that some of the physicians performing procedures here have a direct financial ownership interest in this center.

**In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.**

1. The fee that we charge for our services covers the non-professional component of your procedure also known as the “technical” or “facility” fee which includes the cost of operating this facility including equipment, staff, rent, supplies, etc. **You will also receive a separate bill from the physician’s office for their professional services, anesthesia services, and possibly the laboratory for any pathology services. The facility, laboratory and physicians’ professional office are all separate legal entities providing separate and distinct services.**

1. As a courtesy to our patient’s, insurance claims will be submitted on the patient’s behalf to the insurance company specified during the registration process if we have the complete name and address of the insurance company, the subscriber’s name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.

1. We expect all known co-payments and deductibles, except for those due under Medicare/Medicaid or other federal healthcare programs, to be paid at the time of service or as required by the contract between the patient, the insurer and our center. We reserve the right to collect co-pays, deductibles and coinsurance upon notification by the insurer.

1. Some insurers require pre-certification, preauthorization or a written referral.

**It is the patient’s responsibility to understand the insurance plan requirements** and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. If your insurance denies the claim, or holds payment, you may be ultimately responsible for the balance. Below will be listed important information that may be needed by insurance companies to ensure we are in network.

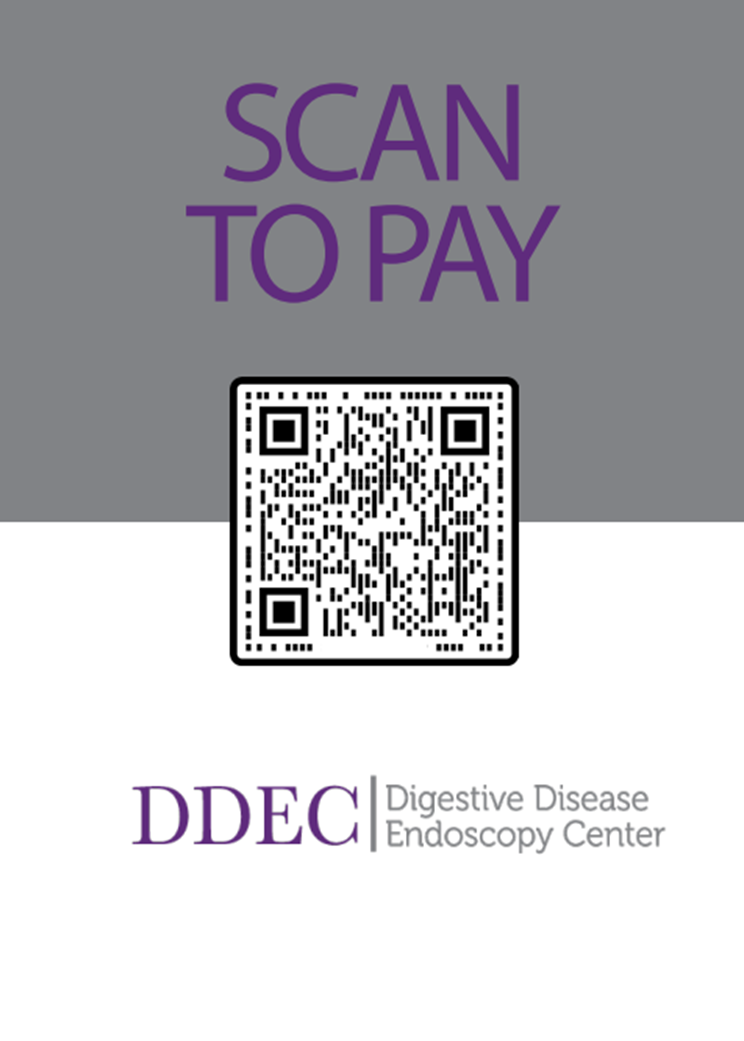
* + **Our legal name is Prairieland Outpatient Diagnostic Center; however, we do business as Digestive Disease Endoscopy Center.** • **Tax ID – 050540368**
  + **Facility NPI – 1255332805**
  + **Anesthesia NPI – 1700252228**

1. **If you have any questions about your account, fees for service or payment policies, please contact our Billing Office to discuss at 1-877-867-8970.** Non-payment will result in referral to an outside collection agency that could impact the patient’s credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient’s responsibility.

We will request that you sign acknowledging you have received a copy of this notice. *Revised 5/5/2022*

A new easy way to pay!

Please scan the QR code to make a payment on our patient portal





**INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY / PROCEDURE(S)**

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

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.

To keep you comfortable during the procedure, medication, defined as Deep Sedation, will be administered by a credentialed Anesthesia Provider as defined in the anesthesia consent.

In the event an anesthesia provider is not utilized, your physician may administer medication defined as Conscious/Moderate Sedation.

## Brief Description of Endoscopic Procedures

1. **EGD (Esophagogastroduodenoscopy**): Examination of the esophagus, stomach, and duodenum. Tissue samples (biopsies) may be removed if the physician deems necessary. If active bleeding is found, coagulation control by heat, medication, or mechanical clips may be performed.

1. **Esophageal Dilation**: Dilating tubes or balloons are used to stretch narrow areas of the esophagus.

1. **Flexible Sigmoidoscopy**: Examination of the anus, rectum and left side of the colon, usually to a depth of 60 cm.

1. **Colonoscopy**: Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis are more prone to complications. Polypectomy (removal of small growths called polyps) is performed, if necessary, by the use of a wire loop and electric current. If active bleeding is found, coagulation control by heat, medication, or mechanical clips may be performed.

Physician explaining procedure: <Performing MD>

## Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, all of the following complications are

possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indications for gastrointestinal endoscopy. YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT 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 may be required.

1. **Bleeding**: Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may occur immediately during the endoscopy or may occur within a few days and may consist only of careful observation, or may require transfusions, repeat endoscopy to stop the bleeding or possibly a surgical operation.

1. **Medication Phlebitis**: Medications used for sedation may irritate the vein in which they are injected. This may cause a red, painful swelling of the vein and surrounding tissue and the area could become infected. Discomfort in the area may persist for several weeks to several months.

1. **Other Risks include but are not limited to**: Post-Polypectomy Burn Syndrome, drug reactions, and complications from other diseases you may already have. Instrument failure and death are extremely rare but remain remote possibilities. Damage to teeth or dental work is not common, but may occur. This includes but is not limited to; cracking, chipping or complete loss of teeth as well as damage to prosthetics including bridges,

implants, caps, or crowns. Please inform your physician if you have any loose dental work, or easily removed bridges. YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

## Alternatives to Gastrointestinal Endoscopy

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. 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 options with you.

I consent to the taking of any photographs during my procedure to assist in my care and for use in the advancement of medical education; for the presence of an observer during the procedure to provide assistance or consultation services to the physician. I certify that I understand the information regarding gastrointestinal endoscopy and sedation. I have been fully informed of the risks, benefits, alternatives and possible complications of my procedure/anesthesia.

I understand that I have been advised that should not drive for twenty four (24) hours following my procedure. I also understand that in the event of cardiac or respiratory arrest or other life threatening situation during my admission, the Center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at Digestive Disease Endoscopy Center, LLC. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care. I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, except as specified by law.

I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

I hereby authorize and permit <Performing MD>to perform the following: <Scheduled Procedure(s)>

**If any unforeseen condition arises during the procedure calling for, in the physician’s judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.**



# INFORMED CONSENT FOR ANESTHESIA SERVICES

1. The anesthesia provider has explained and discussed with me the nature and purpose of proposed anesthesia. This consists of placing a catheter into my vein and administering medicine. My vital signs will be continually monitored throughout the procedure. (Blood pressure, EKG, oxygen saturation, respiration, CO2, and ventilation.)

1. The anesthesia provider has explained and discussed with me the following issues:

· The pre-procedure, procedure, and post-procedure risks of anesthesia include but not limited to:

inflammation of the vein, bruising and/or discoloration at the injected site, trismus of the muscles of the face, lack of coordination, drowsiness, fainting, allergic reactions, vomiting, nausea, damage to teeth or oral tissues, necrosis of tissues at injection site, brain damage, paralysis, cardiac arrest and death.

· The possible or likely results of intravenous anesthesia are to keep me in a sedate or sleep-like state.

· All feasible alterations to the administration of intravenous anesthesia have been explained to me.

· I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees

have been made to me concerning the results of proposed treatment and/or anesthetic.

· The benefits of clinical anesthesia

1. I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates necessary under the circumstances.

1. I understand that the medications I am taking may cause complications or interactions with anesthesia and surgery. I have informed my anesthesia provider about these medications, as well as herbal or over-the- counter/nutritional supplements and/or any recreational/”street” drugs.

1. I certify that I have read and fully understand the above consent statement which I had sufficient time to discuss and that all my questions were answered fully by the anesthesia provider.

1. I consent knowingly and voluntarily to the administration of intravenous anesthesia as outlined above. At all times during the reading, explanation and execution of this form, I possessed all my mental faculties and was not under the influence of alcohol and/or medications.

1. I understand that I am financially responsible for any and all charges related to the anesthesia services provided. As a courtesy to me, I understand Digestive Disease Endoscopy Center will submit claims to my primary and secondary insurance carriers. I authorize Digestive Disease Endoscopy Center to complete any forms which are needed in order to obtain payment from payers including Medicare and Medicaid and all insurance programs in connection with the anesthesia services.

**I consent to the administration of deep, or conscious/moderate and local anesthesia to be administered by a credentialed anesthesia provider at the center.**



**PATIENT AND FAMILY INFECTION CONTROL EDUCATION AND**

**PROCEDURAL SAFETY**

**Before your Procedure:**

Take a shower or bathe the morning of your procedure or before bedtime the night before. Brush your teeth, floss, and use mouthwash before bedtime the night before and the day of your procedure.Please inform your physician or nurse about draining wounds, infections, rashes, skin abrasions or other medical problems you may have. Also inform your physician or the Center should you develop an infection, fever, flu, cold, or cough.

**Procedural Safety:**

The staff will ask you to confirm your name, date of birth, and your procedure multiple times during your stay. Immediately before your procedure, the Endoscopy Team will perform a

“Time Out” to confirm your name, date of birth, the procedure, physician, equipment, pre-op medications/lab work, and any issues particular to your care.

**Hand Hygiene**

The staff will clean their hands with alcohol based hand rub or with soap and water before and after caring for each patient. If you do not see your caregivers cleaning their hands please ask them to do so. Family and friends should also clean their hands before and after visiting you. In addition, they should not visit you if they have an infection, fever, flu, cold, or cough.

**PPE and Precautions:**

The staff will wear Personal Protective Equipment (PPE) - gowns, masks, and gloves during your procedure and any other time deemed necessary to maintain cleanliness and prevent the transmission of infection. There may be occasion staff members isolate a restroom, offer face masks, or state to use soap and water for hand hygiene if necessary.

**Patient Safety During COVID:**

Our Center is committed to COVID safety while providing patients with quality health care. To ensure your health and safety during this time, we are adhering to all Centers for Disease Control (CDC) guidelines. See the link below to view our Center’s COVID-safety protocols. [https://youtu.be/7MYXEXZH5VI.](https://youtu.be/7MYXEXZH5VI)

**After Your Procedure:**

If you develop symptoms of an infection, such as redness or pain at the IV or incision site, drainage, fever, or any concerns call your physician immediately. If you have a wound your physician or nurse should explain how to care for your wound. Always clean your hands before and after caring for your wound.

**Questions:**

Please discuss any elements for safe care with your nurse or the management staff.



# POST ENDOSCOPY INSTRUCTION SHEET

1. Following anesthesia, you are considered under the influence of drugs for 24 hours. DO NOT drive, operate machinery, drink alcohol, make important decisions, or sign legal papers for 24 hours.
2. If you have obstructive sleep apnea, a responsible adult must remain at your side to observe you for at least two hours after discharge. If any breathing problems call 911.
3. Do not take any tranquilizers, sleeping pills, or pain medication today.
4. Gas and bloating is normal after certain procedures. Passing gas and belching is encouraged. Flexing your knees while lying down may be helpful.
5. If you develop a sore throat, gargle with warm salt water or use throat lozenges.
6. Avoid heavy lifting or straining for one week.
7. Notify <Performing MD> immediately if you develop any of the following:

|  |  |  |
| --- | --- | --- |
| Breathing difficulty |  | More than 1 or 2 Tbs. of bright red rectal bleeding |
| Temperature over 100F |  | Increased abdominal bloating |
| Black tarry stools |  | Persistent nausea or vomiting |
| Sudden severe chest or abdominal pain  IV site red, swollen, painful, or infected |  | Vomiting or coughing up blood |

These symptoms could indicate a complication that would require medical attention. If you fail to notify your physician, it could result in more serious consequences. **In case of emergency please call 911 or go to the nearest emergency room.**

1. In the future, call your physician if you develop a change in bowel habits, blood in your stool, or abdominal pain.

I hereby authorize and permit <Performing MD> to perform the following: <Scheduled Procedures>

If any unforeseen condition arises during the procedure calling for, in the physician’s judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

# PATIENT RIGHTS & PATIENT RIGHTS & RESPONSIBILITIES, ADVANCE DIRECTIVES, & DISCLOSURE STATEMENT

## Patient Rights

**As a patient, or as appropriate patient’s representative or surrogate, you have the following rights:**

1. To receive treatment that is respectful of the patient’s personal values & beliefs. To receive the best care possible, consistent with the mission & capabilities of the Center. To be treated with respect, consideration, & dignity for both property & person.
2. To obtain information about the services received.
3. To participate in decisions regarding your care except when participation is contraindicated for medical reasons as well as the right to accept or refuse treatment.
4. To change your provider if other qualified providers are available.
5. To refuse participation in experimental research.
6. To have all communications, disclosures, & records pertaining to your care treated confidentially. Patients are given the opportunity to approve or refuse the release of records except when release is required by law.
7. To examine & receive an explanation of your bill regardless of the source of payment. To receive an explanation of the fees for specific services provided in the Center & payment policies.
8. To receive information from your physician or his designee regarding your after discharge care & following-up activities.
9. To understand provisions for after-hours & emergency care.
10. To the credentials of the health care professionals.
11. To express your grievances & to be informed about the procedure for expressing suggestions, complaints & grievances regarding treatment or care that is or fails to be furnished, including those required by state & federal regulations. The Center will respond in writing or by phone with notice of how the grievance has been addressed.

If you have a concern regarding services or care that cannot be resolved by a staff member, you may request to speak with the administrator at:

Digestive Disease Endoscopy Center:

1302 Franklin Ave., Suite 1000

Normal IL 61761

Phone: 309-268-3400

Fax: 309-268-3423

For concerns about patient safety & quality of care that you feel have not been addressed appropriately by the center Administrator you can also contact:

|  |  |  |
| --- | --- | --- |
| Illinois Department of Public Health:    Office of Healthcare Regulation    (Deputy Director):  525 W. Jefferson St. 5th floor  Springfield, IL 62761  800-252-4343 | The Accreditation Association for Ambulatory  Health Care  5250 Old Orchard Road Suite 200  Skokie, Illinois 60077  Phone: 847-853-6060 Fax: 847-853-9028 [www.aaahc.org](http://www.aaahc.org/) | Office of the Medicare Beneficiary Ombudsman  [*http://www.medicare.gov/claims-andappeals/medicare-rights/gethelp/ombudsman.html*](http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html)  1-800-MEDICARE (1-800-633-4227) |

1. To expect emergency procedures to be implemented without unnecessary delay.
2. To receive impartial access to treatment regardless of race, color, sex, national origin, religion, handicap, or disability.
3. To expect safe transfer when necessary & to have your records accompany you.
4. To receive care in a safe setting free of abuse or harassment.
5. To personal privacy.
6. To exercise your rights, without being subjected to discrimination or reprisal.
7. To be fully informed about a procedure, anesthesia, & the expected outcomes before it is performed. This includes, to the degree known, complete information concerning diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
8. To view your medical record upon request & to obtain a copy. A release form may be obtained from the business office. A copy shall be provided within thirty (30) days of receipt of request.
9. To request a change in your medical record. The facility is obligated to consider the request & notify you of the final decision.
10. To restrict the use of your healthcare information as long as it does not interfere with treatment, payment, or operations.
11. To know who has been given access to your healthcare information.
12. To physician financial interests or ownership in the Center.
13. To services available at the organization.
14. To accurate reflection of the Center’s accreditation.
15. To information related to the absence of malpractice insurance coverage if applicable.
16. To non-misleading marketing or advertising regarding competence and capabilities of the organization.
17. To request that communications about your healthcare be delivered confidentially so that the sender remains anonymous & the information protected.
18. If a patient is adjudged incompetent under the applicable State health & safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under the State law to act on the patient’s behalf.
19. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient’s rights to the extent allowed by State law.

## Patient Responsibilities

**As a patient you have the following responsibilities:**

1. To provide complete, accurate and timely information about your health care status to the best of your ability, including medications, over-the-counter products, herbal remedies, dietary supplements, allergies, sensitivities, and past medical history. To report unexpected changes in condition to the responsible practitioner.
2. To be respectful of health care professionals, staff members, other patients, and property of other persons and the Center.
3. To adhere to the treatment plans recommended by your physician/ provider and to participate in your care. To cooperate with your physician and Center staff by:
   * Following the policies and procedures of the Center.
   * Following staff directions.
   * Ask any and all questions of the physician and staff in order to have a full knowledge of the procedure and aftercare or if something is unclear.
   * Informing someone if you have specific needs or limitations that may require adaptation or if you choose to refuse treatment.
4. To be considerate of other patients in the Center and to direct any family members and or friends to act in a similar manner.

(controlling noise, distractions, and avoiding smoking.)

1. To understand that you will receive separate bills. One from your physician’s office, one from our facility, and possibly from other outside services
2. To promptly pay for services rendered consistent with your current health insurance plan, including any self-pay portions.
3. To tell your physician about any living will, power of attorney, or other advanced directives. 8. To arrange for a responsible adult to take you home and remain with you for 24 hours if required by your physician.

## Advance Directives

You have a right to make an advance directive. You have a right to make decisions about the health care you receive now and in the future. An Advance Directive is a written statement about how you want medical decisions made when you can no longer make them. Illinois has three advance directives: health care power of attorney, living will and mental health treatment preference declaration. Call us at 309-268-3400 about Advance Directives and how to access the forms you will need if you are interested.

**Statement of Limitation (755ILCS35/) ASC Wide Conscious Objection:**

**(Applies to all procedures that take place in the facility)**

Due to the fact that the Digestive Disease Endoscopy Center is an Ambulatory Surgery Center for the purpose of performing elective Endoscopy in a safe and uncomplicated manner, patients are expected to have an excellent outcome. If a patient should have a complication and in the event of deterioration, the center staff will always attempt to resuscitate the patient and transfer the patient to Carle BroMenn Medical Center where the hospital’s policy regarding Advance Directives will be followed. A copy of the patient’s advance directive is provided to the hospital in the event of a transfer. The Administrator, physicians, and or Nurse Manager will speak with any patient who presents an Advance Directive during registration who has concerns regarding the Center’s policy. Additional information can be obtained at http://www.idph.state.il.us/public/books/advin.htm

## Disclosure Statement

Digestive Disease Endoscopy Center is an **independently owned limited liability company** comprised of local area physicians;

Dr. Kenneth R. Schoenig, Dr. Vijay Laxmi Misra, Dr. Robert E. Clark, Dr. Darryl Fernandes, Physicians Endoscopy, and Carle/BroMenn Medical Center. Digestive Disease Endoscopy Center operates independently of Carle/BroMenn Medical Center and was established to provide state-of-the-art cost effective gastrointestinal Endoscopy services in an easily accessible facility.

*Revised 11/12/2020*

### NOTICE OF PRIVACY PRACTICES

**DIGESTIVE DISEASE ENDOSCOPY CENTER**

Effective Date: September 23, 2013revised June 02, 2022

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

**This Notice shall be applicable to the following entities:**

* **DIGESTIVE DISEASE ENDOSCOPY CENTER** (the “Center”)
* **Illinois Gastroenterology Group**
* **GI PATHOLOGY(POPLAR HEALTHCARE)**
* **KMB SERVICE CORPORATION**
* **CARLE BROMENN LABORATORY**
* **CARLE BROMENN RADIOLOGY**

**NOTE:** Independent healthcare providers rendering care or treatment to you at the Center (e.g., surgeons, anesthesiologists, radiologists, pathologists) will also abide by the terms of this Notice with respect to your protected health information concerning care or treatment rendered to you at the Center. Accordingly, such independent providers may use and disclose protected health information about you concerning care or treatment rendered to you at the Center for the purposes discussed in this Notice (e.g.,their own payment activities) and to the same extent as the Center may make such uses or disclosures under the terms of this Notice. Such independent providers may, however, have different policies or notices regarding their use and disclosure of medical information maintained by them concerning care or treatment rendered to you outside of the Center. Please note that such independent providers are neither employees nor agents of the Center, but are joined under this Notice for the convenience of explaining to you your rights relating to the privacy of protected health information about you concerning care or treatment rendered to you at the Center.

If you have any questions about this notice or need further information, please contact our Privacy Officer at **309-268-3400**. Written requests should be addressed to:

**Digestive Disease Endoscopy Center**

Attn: Privacy Officer

**1302 Franklin Avenue Suite 1000 Normal, Illinois 61761**

**OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION:**

The privacy of your protected health information or “PHI” is important to us. This notice will tell you about the ways in which we may use and disclose your PHI. This notice describes your rights with respect to your PHI we collect and maintain and also describes certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

1. Maintain the privacy of your PHI;

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your PHI we collect and maintain;
2. Notify you if we discover a breach of any of your PHI that is not secured in accordance with federal guidelines; and

1. Follow the terms of the Notice of Privacy Practices that is currently in effect.

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:**

You have the following rights with respect to your PHI:

* 1. **Right to Inspect and Copy:** You have the right to inspect and copy all or any part of your medical or health

record, as provided by federal regulations. You may request and receive an electronic copy of your PHI if we maintain your PHI in an electronic health record.

To inspect and copy your PHI, you must submit your request in writing to our Privacy Officer at the address listed on the first page of this notice. If you request a copy of your PHI we may charge a reasonable, cost-based fee in accordance with state law for the costs associated with fulfilling your request.

We may deny your request under certain limited circumstances.

* 1. **Right to Amend:** You have the right to request that we amend your PHI or a medical or health record about you if you feel that health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to our Privacy Officer at the address listed on the first page of this notice, and must provide a reason that supports your request for an amendment. We may deny your request under certain limited circumstances.

* 1. **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your PHI we have made, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. If you request an accounting of disclosures of your PHI, the accounting may include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic

health record.

To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer at the address listed on the first page of this notice. Your request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

* 1. **Right to Request Restrictions:**  You have the right to request a restriction or limitation on the use and

disclosure of your PHI. You also have the right to request a restriction or limitation on the disclosure of your PHI to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your PHI or that we not disclose information to your spouse about a surgery you had.

If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third party payor for purposes of payment or health care operations. We are obligated by law to abide by such restriction.

To request a restriction on the use and disclosure of your PHI, you must make your request in writing to our Privacy Officer at the address listed on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limitations to apply. We will notify you of our decision regarding the requested restriction. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency

treatment.

1. **Right to Receive Confidential Communications:** You have the right to request that we communicate with you about your PHI in a certain way or have such communications addressed to a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to our Privacy Officer at the address listed on the first page of this notice. Your request must specify how or where you wish to be contacted.

1. **Right to a Paper Copy of this Notice:** You have the right to obtain a paper copy of this notice at any time

upon request. At the time of first service rendered, we are required to provide you with a paper copy of this notice. To obtain a copy of this notice at any other time, please request it from our Privacy Officer at the address listed on the first page of this

notice.

1. **Right to Revoke Authorization:** If you execute any authorization(s) for the use and disclosure of your PHI,

you have the right to revoke such authorization(s), except to the extent that action has already been taken in reliance on such authorization.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:**

The following categories describe different ways that we may use and disclose your PHI without your authorization.

1. **For Treatment:** We may use your PHI to provide you with health care treatment or services. We may disclose

your PHI to other doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. For example, another doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

1. **For Payment:** We may use and disclose your PHI so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your visit to our practice so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
2. **For Health Care Operations:** We may use and disclose your PHI for operations of our practice. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for

you.

1. **For Research:** We may disclose your PHI for the purpose of research. We will only disclose your PHI for research purposes upon your express authorization or if the research protocol has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

1. **As Required By Law:** We may disclose your PHI when required to do so by federal, state, or local law.

1. **To Avert a Serious Threat to Health or Safety:** We may use and disclose your PHI when necessary to

prevent a serious threat to your health and safety or the health and safety of the public or another person.

1. **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release your PHI as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military

authorities.

1. **Workers’ Compensation:** We may release your PHI as authorized by, and in compliance with, laws related to workers’ compensation and similar programs established by law that provide benefits for work-related illnesses and injuries without regard to fault.

1. **Public Health Activities:** We may disclose your PHI for public health activities. These activities generally

include the following:

* + to prevent or control disease, injury, or disability;
  + to report births and deaths;
  + to report child abuse or neglect;
  + to report reactions to medications or problems with products;
  + to notify people of recalls of products they may be using;
  + to notify person or organization required to receive information on FDA-regulated products; and
  + to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

1. **Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized

by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

1. **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

1. **Law Enforcement:** We may disclose your PHI to law enforcement officials for law enforcement purposes

including the following:

* + in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
  + in response to a court order, subpoena, warrant, summons or similar process;
  + to identify or locate a suspect, fugitive, material witness, or missing person;
  + about the victim of a crime, if the victim agrees to disclose or under certain limited circumstances, we are unable to obtain the person’s agreement;
  + about a death we believe may be the result of criminal conduct;
  + about criminal conduct at our facility; and
  + in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

1. **Organ and Tissue Donation:** We may disclose your PHI to organizations involved in the procurement, banking,

or transplantation of cadaveric organs, eyes or tissue, for the purpose of facilitating organ and tissue donation where applicable.

1. **Abuse, Neglect and Domestic Violence:**  We may disclose your PHI to an appropriate governmental authority

if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

1. **Coroners, Health Examiners and Funeral Directors:** We may disclose your PHI to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors as necessary to carry out their duties.

1. **National Security and Intelligence Activities:** We may disclose your PHI to authorized federal officials for

intelligence, counterintelligence, and other national security activities authorized by law, or for the purpose of providing protective services to the President or foreign heads of state.

1. **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we

may disclose your PHI to the correctional institution or law enforcement official. This release would be necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

**EXAMPLES OF OTHER PERMISSIBLE OR REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:**

1. **Business Associates:** Some of our activities are provided on our behalf through contracts with business associates. Examples of when we may use a business associate include coding and claims submission performed by a third party billing company, consulting and quality assurance activities provided by an outside consultant, billing and coding audits performed by an outside auditor, and other legal and consulting services provided in response to billing and reimbursement issues which may arise from time to time. When we enter into contracts to obtain these services, we may need to disclose your PHI to our business associate so that the associate may perform the job which we have requested. To protect your PHI, however, we require our business associate to appropriately safeguard your information.

1. **Notification:** We may use or disclose your PHI to notify or assist in notifying a family member, personal

representative, close personal friend, or other person responsible for your care of your location and general condition. **We** **will not disclose your PHI to your family members, personal representative or close personal friends as described in this paragraph if you object to such disclosure. Please notify our Privacy Officer if you object to such disclosures.**

1. **Communication with family members:** Health professionals, including those employed by or under contract

with us may disclose to a family member, other relative, close personal friend or any other person you identify, health information relative to that person’s involvement in your care or payment related to your care, unless you object to the disclosure.

1. **Unlawful conduct:** Federal law allows for the release of your PHI to appropriate health oversight agencies,

public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**WE MAY NOT USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE FOLLOWING PURPOSES WITHOUT YOUR AUTHORIZATION:**

1. We must obtain an authorization from you to use or disclose psychotherapy notes unless it is for treatment, payment or health care operations or is required by law, permitted by health oversight activities, to a coroner or medical examiner, or to prevent a serious threat to health or safety.
2. We must obtain an authorization for any use or disclosure of your PHI for any marketing communications to you

about a product or service that encourages you to use or purchase the product or service unless the communication is either (a) a face-to-face communication or; (b) a promotional gift of nominal value. However, we do not need to obtain an authorization from you to provide refill reminders, information regarding your course of treatment, case management or care coordination, to describe a health-related products or services that we provide, or to contact you in regard to treatment alternatives. We must notify you if the marketing involves financial remuneration.

1. We must obtain an authorization for any disclosure of your PHI which constitutes a sale of such PHI.
2. **We must obtain an authorization for all other uses and disclosures of your PHI not described in this**

**notice.**

If you provide us with written authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time.

**CHANGES TO THIS NOTICE:**

We reserve the right to change our privacy practices and any terms of this notice. If our privacy practices materially change, we will revise this notice and make copies of the revised notice available upon request. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future.

**TO MAKE A COMPLAINT:**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the number listed on the first page of this Notice. All complaints must be submitted in writing. **There will be no retaliation against you for filing a complaint.**

**ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:**

We will request that you sign a separate form acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, and date. This acknowledgement will be filed with your records.

*Revised 6/02/2022*

**Clear Liquid Diet for Colonoscopy**

**Drinks/Foods that are OKAY**

* Water
* Black Coffee (or Tea) **WITHOUT** milk or cream
* Sports drinks with electrolyte **(no red or purple dye)**
* Carbonated beverages and sodas
* Pulp free fruit juice **(no red or purple dye)**
* 100% pure cranberry juice
* Clear broth
* Honey
* Hard candies
* Gelatin **(no red or purple dye)**
* Popsicles **(no red or purple dye)**
* Fruit Ices **(no red or purple dye)**
* Sorbet **(no red or purple dye)**
* Pedialyte