Forms given to patient: Date _____ Signature _____

BALTIMORE AMBULATORY CENTER FOR ENDOSCOPY

Last Name: _____ First Name: _____ M.I. ___ SSN: _____

Address: _____ City: _____

State: _____ Zip code: _____ Home Phone: _____ Mobile: _____

Employer: _____ Work Phone: _____

Sex: ☐ M ☐ F Age: _____ Date of Birth: _____ Marital Status: ☐ M ☐ S ☐ W

Emergency Contact Person's Name and Phone Number: _____

Pharmacy Name and Phone Number: _____

Primary Care Physician, Phone Number and Address: _____

Please call us immediately at 410-574-7776 if you have any of the following and your BACE physician is not aware of this:

- Had to go to the emergency room/urgent care facility since you saw your BACE physician in his office.
- Have an internal defibrillator or pacemaker.
- Have an active infection/fever.
- If you are allergic to latex (rubber gloves, balloons)
- If you are pregnant or think you could be.

PROCEDURE AND BILLING COMMUNICATION PERMISSION

I give my permission for BACE staff and/or the physician performing my procedure today to communicate information regarding my procedure results and/or billing. **PLEASE CHECK THE APPROPRIATE BOXES:**

- YOU MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE AND/OR VOICEMAIL WITH INFORMATION TO RETURN PHONE CALL. THIS MESSAGE WILL ONLY INCLUDE PHONE NUMBER AND TIME TO CONTACT US.

  ☐ YES ☐ NO _____ Initials

- IF I AM NOT AVAILABLE, YOU MAY LEAVE THE RETURN CALL INFORMATION WITH THE FOLLOWING PEOPLE (SPOUSE, FAMILY MEMBER, FRIEND):

  NAME(S): _____ _____Initials

In order to provide you with the highest quality of care please answer these questions:

1. We will provide written and verbal information regarding your care at BACE. What method do you prefer in order to get the best understanding? ☐ Written ☐ Verbal ☐ Other _____
2. Do you have any beliefs or practices that might affect how we give you information/patient education/ instructions or care for you at BACE (such as religious, cultural, spiritual beliefs)? If yes, please explain:

   _____

   _____
3. Do you have problems with your vision or hearing that might affect the way we give you information?

   ☐ Yes ☐ No If yes, please explain: _____

   _____

4. Is English your main language? If no, what is your main language: _____
5. Responsible party who brought you today will be required to wait in the waiting room until you are discharged. They should not leave BACE and return. IF FOR ANY REASON YOUR DRIVER MUST LEAVE, YOUR PROCEDURE WILL BE POSTPONED UNTIL THEY RETURN. Do you want this person in the Recovery Room when the nurses review your discharge instructions with you?

☐ Yes Name of person: _____ ☐ No

6. When did you have your office visit with your BACE physician? Date: _____
7. Have you had a procedure at BACE in the past? ☐ Yes Date: _____ ☐ No

Signature of patient or legal guardian

Date

BALTIMORE AMBULATORY CENTER FOR ENDOSCOPY (BACE)

ANESTHESIA FACTS AND CONSENT

PROPOFOL SEDATION/DEEP SEDATION

The drug propofol is far superior when compared to alternative anesthetic agents. It works fast and wears off considerably faster. In fact, most patients experience very few side effects as opposed to more traditional drugs which can leave a person groggy for hours after the procedure. This is the drug you will be receiving with the possibility of supplementary drugs depending on your health status.

A Certified Registered Nurse Anesthetist (CRNA) will administer your anesthesia. When you get to the procedure room an intravenous line (IV) will be started on you. This IV will be used to supply your medication and replace fluids throughout the procedure. The drugs that are given during your procedure with deep sedation will allow you to take a short nap while your doctor does the procedure. You can expect monitoring equipment to be attached when you are in the procedure room (blood pressure cuff, heart monitor leads, pulse oximeter and oxygen). This is routine for all patients undergoing a procedure at BACE. The anesthesia given to you will cause you to have little recollection of the procedure.

DURING YOUR PROCEDURE

When receiving any deep/moderate sedation your safety is most important. The anesthetist assures your safety by using monitoring devices throughout the procedure. In fact, your anesthetist will be responsible for controlling your level of consciousness and will use these monitors to keep vigilant watch on your vital signs such as heart rate and rhythm, blood pressure and oxygen levels.

WHAT ARE THE RISKS/SIDE EFFECTS?

Although anesthesia is considered very safe, it is not risk free. It is important for you to have the opportunity to discuss risks with your CRNA/Anesthesiologist prior to your procedure. They are the best person to know how your individual situation may affect any risk. Therefore you must provide the following important information: your current and previous medical conditions, your history with anesthesia, your current medications including prescribed, over the counter and herbal supplements,and any habits such as smoking, alcohol use or illegal drug use. All of these can influence the risks of certain complications so they need to be disclosed prior to administration of anesthesia.

Possible risks/complications involved in the administration of anesthesia include, but are not limited to: difficulty breathing, aspiration (drawing in) of fluid into the lungs which could cause pneumonia, change in heart rhythms (cardiac arrhythmias), stroke, cardiac arrest, or death. Possible side effects may include, but are not limited to: potential injury to neck or jaw, discomfort and swelling at the IV site, nerve damage, drug reactions, nausea and vomiting, light-headedness, blurred vision, fatigue, fever, temporary loss of memory, dental trauma including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings and laceration of the gums or lips. If any side effects persist you should notify your physician.

I certify that to the best of my knowledge, I have provided in detail my medical and surgical history, including the following information:

- All medical problems
- Previous surgical procedures
- Any recent illness/hospitalization
- Medication and food allergies (including the type of reaction)
- Surgical implants (pacemakers, AID, stents, prosthetic valves, total joint replacements)
- Smoking and recreational drug use (including alcohol)
- Past experience with anesthesia (personal or family)
- Current medications (including all over-the-counter medicines, herbal, alternative complementary medicines, vitamins and prescription medications.

I have read the above information describing the type of anesthesia used at BACE and the possible risks and side effects. I understand that all types of anesthesia involve some risks and complications that while rare, do sometimes occur. I have been given the opportunity to ask questions about my anesthesia and alternative treatments. I agree to the administration of the appropriate anesthesia for my procedure.

___ Upon request I will receive written information regarding my nurse anesthetist's current licensure, relevant education, and training/experience before he/she administers any type of anesthesia.

Signature of Patient: _____ Date: _____

ANESTHESIA PROVIDER STATEMENT

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/responsible adult ample time to ask questions.

Anesthesia Provider: _____ Date/Time: _____

BALTIMORE AMBULATORY CENTER FOR ENDOSCOPY (BACE)

Financial Agreement

In the event that my insurance will not pay all or part of the Center's and/or physicians charges at Baltimore Ambulatory Center for Endoscopy (BACE) or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such a claim. I understand that I am responsible for any deductibles, co-insurance, co-pays or other amounts not covered by my insurance company. **WE WILL EXPECT PAYMENT AT THE TIME OF SERVICE FOR YOUR OUTPATIENT FACILITY CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND/OR OUSTANDING BALANCE.** For patient's convenience we accept Visa, MasterCard, Discover, Care Credit as well as cash or personal check. You will receive a telephone call from BACE or our billing service several days before your procedure and we will inform you of the amount of your co-pay, deductible or co-insurance that is due. **IF AT THIS TIME YOU ALSO HAVE AN OUTSTANDING BALANCE, YOU MUST PAY AT LEAST HALF OF THE OUTSTANDING BALANCE BEFORE HAVING YOUR PROCEDURE DONE. IF YOU PAY HALF OF YOUR OUTSTANDING BALANCE THEN WE CAN SET UP A PAYMENT PLAN FOR THE REMAINING BALANCE. IF YOU CHOOSE NOT TO PAY HALF OR MORE OF YOUR OUTSTANDING BALANCE, THEN YOUR PROCEDURE WILL BE CANCELLED/ RESCHEDULED UNTIL YOU CAN DO SO.** In addition to this, you will also be responsible for the amount that is due for your current procedure. You have the option of paying over the phone or bringing the payments with you the day of your procedure. If you arrive at BACE without your current payments that are due, your procedure may be cancelled. A fee schedule is available. Please be advised that physician, pathology and anesthesia services are separate from the facility fee. Self pay patients are expected to pay the agreed upon balance at the time of service. Pre-authorization and/or referrals must be obtained prior to the procedure. If the referral is not available at the time of the procedure, services may be denied until it is obtained.

Assignment of Insurance Benefits

I hereby assign benefits to be paid on my behalf to BACE, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. **I certify that the information given with regard to insurance coverage is correct at time of service or I am fully responsible for all fees incurred**.

Release of Medical Records

I authorize BACE, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation for the purposes of submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care, treatment and health care operations.

Disclosure of Ownership Notice

I have been informed prior to the date of the procedure, that the following physicians: Dr. J. Khan, Dr. J. Lin, Dr. V. Sivan, Dr. M. Luhar who perform procedures/services at BACE have ownership/financial interest in the center. The physician's have given me the option to be treated at another facility/center, which I have declined. I wish to have my procedure/services performed at BACE.

HIPAA Privacy Notice Acknowledgement

I hereby acknowledge that a copy of the Notice of Privacy Practices for BACE has been made available to me. It is posted in the waiting room and I have the right to obtain a paper copy upon request. The posted Privacy Practices have more detailed information about the usage and disclosure of your protected health information. We reserve the right to amend the terms of our posted privacy policy.

Patient's Rights Information

I have received information regarding my Patient's Rights prior to the date of the procedure.

Attention Female Patients

For your own safety all women age 55 and younger will be required to have a urine pregnancy test done upon arrival at BACE. This is done to minimize the risk of potential adverse effects on a developing fetus. The only exception to this requirement will be women who have had a hysterectomy. Being on any type of birth control does not exclude you from having a pregnancy test. There is no extra fee associated with this test.

Certification of Patient Information

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to this center is correct. I also certify to the best of my knowledge, I have provided my complete medical and surgical history including current medications and allergies.

Upon request I will receive written information regarding my physician's current licensure, relevant education, training and experience before he/she performs the procedure.

I certify that I have read, understand and accept the terms of this document and that I am the patient duly authorized to execute it.

Signature of Patient/Patient Representative/Patient Surrogate	Print Name
Relationship to Patient	Date Signed

LATEX ALLERGY QUESTIONNAIRE

1. **Have you ever been diagnosed with a latex sensitivity/allergy?**
   Yes No
2. **Have you ever had swelling, itching or hives on your lips, around your mouth or experienced breathing problems after blowing up a balloon?**
   Yes No
3. **Have you had skin reactions to plastic band aid adhesives?**
   Yes No
4. **Have you ever had swelling, itching or hives after a dental exam?**
   Yes No
5. **Have you ever had swelling, itching, hives, eye irritation, runny nose or difficulties with breathing after contact with any rubber or latex products listed above on this handout?**
   Yes No
6. **Are you allergic to avocados, bananas, kiwi, chestnuts, papaya, melon or other fruits?**
   Yes No
7. **Have you ever had a strong allergic reaction(anaphylaxis) or other unexplained reactions during a medical procedure?**
   Yes No

We try to maintain a "latex safe" environment but it may not be totally latex free; so this is why we must evaluate you for a latex sensitivity/allergy and take appropriate measures if necessary. You may need to have the latex allergy blood test(RAST) before having your procedure done, so it is very important to complete this form and notify the physician`s office with the information.
Thank you for your cooperation and honesty in answering these questions so that we can provide you with the safest and most optimal healthcare.

The Staff at BACE

Patient Signature_____ Date_____

ARE YOU ALLERGIC TO LATEX?

Latex allergies are on the rise. Since latex is everywhere in the health care settings and the home we need to know whether or not you could be allergic to latex before your procedure is scheduled. In the healthcare setting latex may be found in many products that we use such as: gloves, blood pressure cuffs, IV tourniquets, injection ports in IV tubing, enema tips, rubber tops of medication vials, nasal oxygen tubing and many more products. In the home latex can be found in: balloons, condoms, underwear waistbands, rubber bands, diapers, pacifiers, athletic shoes, erasers, scratch off portion of instant lottery tickets, telephone cords, garden hoses and many more products. Latex is not only in these products but it can get into the air from these products(powder from gloves) and create a latex reaction. Also if you have a food allergy to any of the following you may also be allergic to latex: avocados, bananas, kiwi, chestnuts, papaya, and melon.

Some of the symptoms that can occur with a latex allergy are: hives, itching, runny nose, asthma symptoms(difficulty breathing or wheezing), chest tightness and much more serious anaphylactic shock(decrease in blood pressure, wheezing, rapid heartbeat, flushing of the face and swelling of the throat.)

If you have had a previous reaction to one of the above products or foods, have been told you have a latex allergy, have had a positive blood test for latex allergy, or answer "yes" to any of the following questions than please notify the physician/nurse/receptionist prior to scheduling your procedure. If you have had the latex allergy bloodwork done and the results are negative we will need a copy of the results prior to your procedure. Have your doctor fax(410-574-9038) the results to BACE. Please call BACE(410-574-7776) the day before your procedure to confirm that we have received the fax. If you complete this form at home and answer yes to one or more questions, please call the physician`s office prior to coming in for your procedure. We will need to address this issue with you. Please be honest when answering these questions. If you answer "yes" we will discuss the details of your reaction to a latex product in order to determine if you will need further testing before your procedure. If you have answered yes to a question and did not contact your physician prior to the procedure than your procedure may be cancelled.

Baltimore Ambulatory Center for Endoscopy
Information on Advance Directives

After reading this information, PLEASE ANSWER THESE QUESTIONS:

- I have received a copy of BACE Information Sheet on Advance Directives prior to my procedure and I agree to have my procedure done at BACE.
- I HAVE AN EXECUTED ADVANCE DIRECTIVES. _____YES _____NO
- I BROUGHT A COPY OF MY ADVANCE DIRECTIVES. _____YES _____NO

Advance Directives allows a person to give directions about medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. This designated person should be someone you trust to make health care decisions for you. They should know what your instructions are and they should follow them. You may want to choose one or two "back up" persons, in case your first choice isn't available when needed. Advance Directives may include living wills, durable powers of attorney or similar documents (Do Not Resuscitate) portraying a patient's preference. The existence of an Advance Directive or lack of one, will not determine a patient's access to care, treatment or service. Once you make an Advance Directive it does not expire. It remains in effect until you revoke it and only you can change it.

IF YOU HAVE AN ADVANCE DIRECTIVE, WE ASK THAT YOU BRING IT WITH YOU.

If you would like information about Advance Directives we can give you a copy of "Maryland Advance Directive: Planning for Future Health Care Desicions". This is a helpful guide with forms included on Maryland law and health care decisions. You can also refer to the websites: www.oag.state.md.us or www.caringinfo.org to get more information about Advance Directives. Other options are discussing this with your primary care physician or calling the Department of Aging at (410) 767-1100.

We want you to know that it is our policy at BACE to honor a patient's Advance Directives to the maximum extent that is practical. However, should an emergency situation happen to a patient while he or she is in our facility, it is our policy to stabilize the patient and transport the patient to the hospital with a copy of their Advance Directive. If the patient has specific circumstances surrounding their Advance Directives this must be discussed with the physician prior to their procedure. If a patient disagrees with our policy at BACE then the patient will have to be rescheduled at the hospital.

The staff and physicians will be happy to answer any questions that you have about Advance Directives that is within the scope of our knowledge. Otherwise we will refer you to someone who can answer your questions more thoroughly.

_____ _____

Signature of Patient/Patient Representative/Patient Surrogate Date

TRANSPORTATION POLICY

PLEASE READ CAREFULLY

TO ALL PATIENTS HAVING A PROCEDURE DONE AT BALTIMORE AMBULATORY CENTER FOR ENDOSCOPY. (BACE)

Since you are being sedated during your procedure, you will not be able to drive a car for at least 12 hours after your procedure. Therefore you **MUST** have a responsible adult accompany you on the day of your procedure. The following policies also apply:

- The responsible party who comes with you for your procedure will be required to wait in the waiting room until you are discharged. They should not leave BACE for any reason. If an emergency occurs we need to have the responsible party available. If the responsible party must leave then your procedure will be postponed until they return. There is also the possibility of cancellation if the situation involves delaying other patient's procedures.
- You cannot be dropped off at BACE and state that "your responsible party will return to pick you up." Providing your responsible party's phone number will not be permitted.
- You may go home in a cab but you **MUST** have a responsible adult (family member, friend, neighbor) accompany you in the cab.
- You may go home by a car service (Mobility, SafeRide) but you **MUST** have a responsible adult (family member, friend, neighbor) accompany you in the car service.
- You CANNOT go home in a cab/car service alone (the cab driver is not considered your "responsible adult")
- You **CANNOT** sign an Against Medical Advice form to be allowed to go in a cab alone.
- If you arrive at BACE without a responsible adult to drive/accompany you home, your procedure **WILL BE CANCELLED**.

Under no circumstances will we make exceptions to these policies. Since all of this information is given in advance of your procedure, you should have ample time to find someone to accompany you. Your responsible party should also make arrangements to stay at BACE during your entire visit. If you are uncertain that you can find someone to accompany you and stay in the waiting room, then your procedure will not be scheduled or, if already scheduled, will have to be rescheduled until you can.

I certify that I have read, understand and accept the policies above.

_____ _____

Signature of patient or legal guardian Date

Thank you, BACE staff

BALTIMORE AMBULATORY CENTER FOR ENDOSCOPY

PATIENT BILL OF RIGHTS

- To expect to be treated with respect, consideration, and dignity.
- To receive care in a clean, safe, non-threatening environment.
- To be assured confidential treatment of disclosure of records and afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law of third party payment contract and when release is required by law.
- To know the name and function of any person providing healthcare services to the patient.
- To know the names and professional relationships of other physicians who may care for him/her in the absence of the attending physician or if I chose to change physicians or get a second opinion by a BACE physician.
- To be provided, to the degree know, information concerning their diagnosis, treatment, and prognosis pre-procedure. When it is not medically advisable to give such information to the patient, the information will be made available to an appropriate person on his/her behalf.
- To have the opportunity to participate in decisions involving their health care and the right to refuse to participate in experimental research.
- To request a second opinion.
- To expect sufficient response to any reasonable requests he or she may make for service.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action.
- To expect communication in the language which they understand.
- To expect treatment without regard of race, creed, color, religion, sex, national origin or source of payment, except for the fiscal capability thereof.
- To know the services available and the policies concerning payment of fees.
- To examine and receive an explanation of the bill, regardless of the source of payment.
- To expect reasonable continuity of care and to know in advance the time and location of appointments.

- To designate any area wherein care is given as a non-smoking area.
- To be able to leave BACE even against the advice of the physician.
- To have all the patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. This can be the patient's representative or the patient's surrogate.
- To be free from all forms of abuse or harassment.
- To provide a pain management plan that addresses any reports of pain, information about pain relief measures, a concerned staff committed to pain management and quick response to any reports of pain.
- To be provided, upon request, information or guidance about formulating advance directives.
- To have their privacy respected at all times.
- To have the right to allow the family to participate in any care decisions that need to be made while at BACE.
- To be able to file a grievance against a professional if necessary. Contact MD Board of Physicians at 410-764-2480 or MD Board of Nursing at 410-585-1925.
- If you would like to file a complaint/grievance, these are your options. Contact any of the options listed below to be told the available steps that are taken to address the complaint/grievance:

  >> Contact the Nurse Manager or Medical Director in person or at 410-574-7776

  >> Contact by mail or by phone:
  Office of Health Care Quality
  7120 Samuel Morse Drive
  2nd Floor
  Columbia, MD 21046
  Phone: 410-402-8040

  >> Contact the Office of the Medicare Beneficiary Ombudsman at:
  http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

After contacting one of the above, you should expect to be given the results of the complaint/grievance process and the date of completion of this process.

BALTIMORE
AMBULATORY
CENTER for
ENDOSCOPY

PATIENT MEDICATION LIST

If you have a list of your current medication.
We would like to make a copy.

410-574-7776

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ Date of Birth: _____

List all medications (prescription, over-the-counter, vitamins, herbal supplements

Drug Name	Dosage	Vitamins/ Herbal supplements	Dosage

These are the medications I have been taking as of this date.

_____ _____ _____

Patient Signature **Date** **Reviewed by nurse**

For Office Use Only

Medication Changes: YES / NO Date: _____ Initials: _____