LAKESIDE ENDOSCOPY CENTER

17001 Lakeside Hills Plaza, Suite 201 ▪ Omaha, NE 68130
Ph: (402) 614-2300 ▪ Fax: (402) 614-0123
www.lakesideendoscopy.com

Thank you for choosing Lakeside Endoscopy Center, LLC, for your upcoming procedure.

In an effort to make the registration process more efficient, please bring the following items:

- The enclosed paperwork. Some forms are double-sided. Please complete both sides.
- Your insurance card(s) so that we may facilitate filing with your insurance company.
- A photo ID is required to ensure and protect your identity.

*Please note: This facility is not located at the hospital. Refer to the enclosed pamphlet for our location at the Lakeside Campus.

If you have informed our scheduling department that you will require interpretive services, these services will be provided by Cyracom, Alegent Health, and Nebraska Relay for our patients. If you chose to have alternate interpreter services, the cost of these services will be the responsibility of the patient. If you will require these services and have not notified our scheduling department, please contact our office to arrange services.

If you have any questions, please do not hesitate to call us at (402) 614-2300.

Patient Label Here

LAKESIDE ENDOSCOPY CENTER, LLC

REGISTRATION FORM

PLEASE FILL OUT THIS FORM **COMPLETELY** AND **LEGIBLY.** This form needs to be presented upon your arrival to the procedure center **along with your photo ID and insurance card(s)**. Thank you.

PATIENT REGISTRATION INFORMATION

Patient Name **AS IT APPEARS ON YOUR INSURANCE POLICY (Be sure to include any prefix, suffix, middle initial, etc).**			Previous/Maiden Name
Street Address	City	State	Zip Code
Birthdate (MM/DD/YYYY)	Social Security Number	Primary Phone Number	Secondary Phone Number
Gender ❒Male ❒Female	Primary Language (CHECK ONE) ❒English ❒Spanish ❒Other ____________	Marital Status: ❒ Single ❒Married ❒Divorced ❒Separated ❒Widowed	
Employer	Spouse	Spouse Primary Phone Number	Spouse Secondary Phone Number

PHYSICIAN INFORMATION

Primary Care Physician Name Did your PCP refer you? ❒Yes ❒No			Referring Physician Name or other Physician to receive report		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code

Would you like a copy of a report from today's procedure to go to both physicians listed above? ❒ Yes ❒ No, only PCP

INSURANCE INFORMATION

Primary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ❒Self ❒Spouse ❒Parent ❒Other:____________	
Secondary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ❒Self ❒Spouse ❒Parent ❒Other:____________	
Tertiary Insurance Company	Policy Holder Name	Relationship of Policy Holder; Check One: ❒Self ❒Spouse ❒Parent ❒Other:____________	
If Policy Holder is **NOT** the patient: First and Last Name Gender: ❒ Male ❒ Female			Birthdate (MM/DD/YYYY)
Street Address	City	State	Zip Code
Social Security Number	Primary Phone Number	Employer	

CONTACT/RIDE INFORMATION

With whom may we discuss your medical care or billing information?

❒ Patient Only ❒ Name of person with whom we may speak: ________________________________

Ride Contact Name	Relationship to Patient	Primary Phone Number	Secondary Phone Number
Emergency Contact Name	Relationship to Patient	Primary Phone Number	Secondary Phone Number

LAKESIDE ENDOSCOPY CENTER, LLC
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you with the best possible care. Thank you in advance for reading this information; it is critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions.

We are here to assist you in providing information to your Health Insurance Company. Please keep in mind that not all services are a covered benefit in all plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Lakeside Endoscopy Center, LLC, is ultimately the patient's responsibility.

If you are scheduled for a colonoscopy: The Affordable Care Act allows for preventative services such as colonoscopies to be covered at no cost to patients. However, certain insurance plans do not follow the Affordable Care Act. There are strict guidelines used to define the type of colonoscopy a physician performs: preventative (screening), diagnostic, or surveillance. Even if your physician recommends that you get a screening colonoscopy, "screening" may not be the category ultimately assigned to your procedure, therefore you may incur additional out of pocket cost. If you have questions please call us at (402) 504-3846 for a more detailed explanation.

If you have insurance, we will submit charges to your primary and secondary insurance provided we have a copy of your assignment of benefits as well as a copy of your insurance card(s). Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. Patients who fail to provide insurance information are directly responsible for payment of their account at the time of service unless other arrangements have been made.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain this prior to your visit. Contact your Insurance Carrier if you are not sure. If an authorization is required it will need to cover your facility charge (Lakeside Endoscopy Center), the physician charge, and anesthesia services. If this is not obtained, your insurance company may deny coverage, which could result in patient responsibility.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems arise, we encourage you to contact our office for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

If you do not have insurance, acceptable financial arrangements will need to be made prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 885-8706. Please note a deposit will be required at the time of procedure.

You will receive multiple billings. These may include the following:

- Facility Fee: Lakeside Endoscopy Center, LLC will bill a charge for the use of the Ambulatory Surgery Center.
- Physician Fee: You will receive a bill from the physician's office that provides the service.
- Anesthesia Services Fee: Monitored Anesthesia Care (MAC) will be provided by a Certified Registered Nurse Anesthetist and be billed by Midwest Gastrointestinal Associates, P.C.
- Laboratory and Pathology Fee: If you have blood drawn and/or a biopsy taken there will be a charge from the laboratory or laboratories that process your blood work and/or biopsy.

If you have any questions regarding your billing(s) please contact us at (402) 885-8706.

Lakeside Endoscopy Service, LLC accepts checks, cash, Visa, MasterCard, Discover, American Express and debit cards.

AUTHORIZATION

I understand that the physician who is rendering services may have an ownership interest in the above referenced facility. The physician or the physician's representative has given me the option to be treated at another facility, which I have declined. I wish to be treated at Lakeside Endoscopy Center, LLC.

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Lakeside Endoscopy Services, LLC. I understand the above stated charges and that I am responsible for my balance in full. I understand I am financially responsible to Lakeside Endoscopy Center, LLC, for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

______________________________ ______________

Signature Date

At Lakeside Endoscopy Center, LLC, patient care, safety & satisfaction are very important to our entire staff. In order to provide the best care possible, we want to partner with you in maintaining your safety & satisfaction. If at any time you, your legal representative and/or surrogate have questions or concerns regarding any aspect of your care, please contact Lakeside Endoscopy Center for assistance or clarification.

Patient Rights

Every patient has the right to be treated fairly, with respect, consideration, dignity and as an individual. We assure the rights of all patients coming into the Center are respected without regard to race, gender, color, national origin, disability, age, religious or fraternal organization, or any other factor protected by law.

1. Patients are treated with respect, consideration, dignity and provided safe care by competent personnel without discrimination.
2. Patients are informed of patient rights during the admission process.
3. Patients are provided appropriate privacy.
4. Patient disclosures and records are treated confidentially, except when required by law, and patients are given the opportunity to approve or refuse their release.
5. Patients are free from abuse, neglect and exploitation.
6. Patients are given access to the information contained in his/her medical record within a reasonable time period when requested.
7. Patients are informed both of their right to formulate an Advance Directive at the time of admission and the facility's policy regarding Advanced Directives.
8. Patients are informed in advance about care, treatment and associated risks.
9. Patients are given information necessary to make informed decisions regarding their care and treatment. When it is medically inadvisable to give information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Patients are provided information about treatment alternatives and will be advised of the risks, advantages and disadvantages of each.
11. Patients have the right to refuse care, treatment and services and to be informed of the medical consequences of refusal of care.
12. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
13. Patients have the right to refuse to participate in experimental research
14. Patients have the right to know, in advance, the type and expected cost of treatment.
15. Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.
16. Patients will receive services without discrimination based upon race, color, religion, gender, national origin, or payer. Health clinics are not required to provide uncompensated or free care and treatment unless otherwise required by law.
17. Patients, families, and /or and legal representatives or surrogates have the right to express grievances and suggestions to the organization without discrimination or reprisal and have those complaints and grievances addressed with in a timely manner.

Advance Directive Policy

Due to the nature of procedures and the generally healthy status of patients seen at the Center it is the conscious decision and policy of the Center **not** to withhold lifesaving actions in the event of life threatening emergencies. In accordance with Nebraska HHS Regulation and Licensure 7-006.04, this will serve as notice to the patient, the patient's representative, or surrogate of the policy limiting advance directives. In the event a life-threatening emergency occurs (i.e. respiratory or cardiac arrest), the Center will perform emergency procedures as necessary to stabilize the patient and then transfer the patient and the advance directive documentation, if provided, to an acute health care facility where the attending physician, the patient's representative or surrogate and family can make an informed decision regarding the patient's well-being.

To comply with state law, during the registration process, you will be asked if you have an advance directive. Please bring a copy if you have one. If you do not have an advance directive and would like further information please call us at 402-614-2300. Upon request we will mail information regarding advance directives or will have it available to you at registration.

Physician Ownership Notice

The physician who is rendering services may have an ownership interest in Lakeside Endoscopy Center, LLC. During the scheduling process, the physician's representative will give you the option to be treated at alternate facilities. If you wish to be treated at another facility please notify your physician's office.

____ ________________________

Patient / Responsible Party Signature Date

Patient Label Here

LAKESIDE ENDOSCOPY CENTER, LLC

PATIENT HISTORY FORM

REASON FOR PROCEDURE (CHECK ALL THAT APPLY):

❒ Screening Colonoscopy
❒ Family history of colon cancer
❒ Personal history of colon polyps/cancer
❒ Personal history of Crohn's Disease
❒ Personal history of Ulcerative Colitis
❒ Blood in stool/rectal bleeding
❒ Reflux
❒ Difficulty swallowing
❒ Nausea/Vomiting
❒ Bloating/Gas
❒ Increased appetite
❒ Decreased appetite
❒ Unintentional weight change:
Gained _______ pounds/Lost ________ pounds
Over how much time? ________________________
❒ Other : ______________________________________
❒ Pain: ____
____
❒ Location: ____________________________________

Please circle one:

1 2 3 4 5 6 7 8 9 10

Very Mild ——————————▶ Severe

Onset/Duration: _________________________________
Type of Pain: ___________________________________
Triggers: _______________________________________
Relief: ____

Tobacco Use: ❒ Never ❒ Former ❒ Current
If current: ❒ Daily ❒ Occasionally Amount: _________
Alcohol Use: ❒ Never ❒ Former ❒ Current
If current: ❒ Daily ❒ Occasionally Amount: _________
Caffeine Use: ❒ Yes ❒ No ❒ Rarely

PATIENT MEDICAL HISTORY (CHECK ALL THAT APPLY):

❒ Stroke
❒ High Blood Pressure
❒ Low Blood Pressure
❒ Cholesterol
❒ Diabetes: ❒ Type I ❒ Type II

Please specify

❒ Lung Disease ______________________________________
❒ Kidney Disease_____________________________________
❒ Heart Disease _____________________________________
❒ Liver Disease ______________________________________
❒ Thyroid Disease ____________________________________
❒ Cancer ____
❒ Seizures Date of last seizure :_____________________
❒ Arthritis ____
❒ Other Diseases _____________________________________
____
❒ Other Infections ___________________________________
____

❒ Hearing Difficulty: ❒ Right Ear ❒ Left Ear ❒ Both
❒ Vision Difficulty ___________________________________
❒ Other: ____
____

Date of last medical examination: ____________________

Prior Anesthesia Problems: ❒ None or please specify:
____
____
____

WOMEN ONLY: Are you currently pregnant? ❒ Yes ❒ No

Allergies & Reactions

____
____
____
____
____

Prior Surgeries– please list

____
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____

Prior Hospitalizations – please list

____
____
____
____

____ ____
Patient Signature Date

____ ____
Reviewing Nurse's Signature Date

Patient label

Home Medication List

This list of medications will assist us in preparing you for your procedure.
Following the procedure this list will serve as your new medication list.

Please fill out this form completely and bring this form with you the day of your procedure.

Include all prescriptions, over-the-counter, herbals, & vitamins/supplements.
Your pharmacy or primary physician can help you if needed.

Medication Name	Dose (mg,units)	Frequency	Last Dose (date/time)	MD use only Continue	MD use only Hold	MD use only Stop
					______days	
					______days	
					______days	
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					______days	
					______days	

New Medications (following procedure)	Dose	Frequency	Special Instructions

Office use only

☐ No medications taken at home
☐ Incomplete medication list
Reason______________________________
Medication information obtained from:
☐ Patient ☐ Caregiver ☐ Medication List
☐ Brought Medications from home
__________________________**Admitting Nurse**

_____________________ **Physician Signature**

_____________________ **Discharge Nurse**

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Original facility copy ◊ Yellow patient copy
Copies to be sent to referring MD office and Endoscopist office