



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 Cyacom, CHI Health, and approved sign language interpreters for our patients. 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 <b>AS IT APPEARS ON YOUR INSURANCE POLICY</b> (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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Primary Language (CHECK ONE) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Employer		Spouse		Spouse Primary Phone Number		Spouse Secondary Phone Number

**PHYSICIAN INFORMATION**

Primary Care Physician Name			Did your PCP refer you? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____				
Secondary Insurance Company		Policy Holder Name		Relationship of Policy Holder; Check One: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____				
Tertiary Insurance Company		Policy Holder Name		Relationship of Policy Holder; Check One: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____				
If Policy Holder is <b>NOT</b> the patient: First and Last Name					Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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, families, and /or and legal representatives or surrogates have the right to effective communication in a manner they can understand. The Center will take reasonable steps, free of charge to the patient, to provide access to tools and services to provide effective communication. These include, but are not limited to interpreters, large print paperwork and selected transcribed documents.
17. 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.
18. 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

**Allergies & Reactions**

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**Prior Surgeries**— please list

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**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

**Prior Hospitalizations** – please list

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\_\_\_\_\_  
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
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
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				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/> ____ days	<input type="checkbox"/>

New Medications (following procedure)	Dose	Frequency	Special Instructions

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Discharge Nurse

**LAKESIDE ENDOSCOPY CENTER, LLC**  
**17001 Lakeside Hills Plaza, Suite 201**  
**Omaha, NE 68130 (402)614-2300**

Office use only
<input type="checkbox"/> No medications taken at home
<input type="checkbox"/> Incomplete medication list
Reason _____
Medication information obtained from:
<input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Medication List
<input type="checkbox"/> Brought Medications from home
_____ Admitting Nurse