



INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Explanation of Procedure

Direct visualization of the digestive tract with a lighted instrument 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 risk of these procedures.

At the time of your examination, the lining of the digestive tract will be inspected thoroughly with a flexible endoscope (with or without biopsy, photography, removal of polyps or injection treatment). Tissue samples may be sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed.

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, all the below complications are possible and may result in hospitalization and additional associated financial costs for which you (the patient) would be responsible. Your physician will discuss the frequency of these complications with you, if you desire, giving particular reference to your own indications for gastrointestinal endoscopy.

YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR PROCEDURE.

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 is usually required.
2. **BLEEDING:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist of observation, repeat of your procedure to control bleeding, transfusions, surgery, or a radiology procedure. If bleeding is noted during the procedure, methods to control bleeding may be used and include, but are not limited to coagulation by heat, placement of clips, injection of medications.
3. **SEDATION/MEDICATION REACTIONS:** There are risks involved with the administration of any medication. These risks may include mild inflammation of the vein at the injection site, nausea, and/or vomiting, allergic reactions to the medications being given, seizures or rarely, heart and/or breathing complications.
4. **MISSED LESIONS OR INCOMPLETE PROCEDURES:** Your doctor will do everything possible to identify all polyps, lesions and cancers. There is always a chance that one or more lesions may be missed by hiding under an intestinal fold or residual stool. Your doctor will make every effort to complete your exam, but occasionally that is not possible due to your anatomy or discomfort.
5. **OTHER:** Additional risks may include complications from other diseases you may already have or damage to teeth/dental work. Rarely, a splenic injury (abrasion or lacerations on the spleen) could occur as the scope passes through the bend of the colon next to the spleen and could result in hospitalization, the need for blood transfusion, and may even require surgery to treat. Instrument failure and death are extremely rare but remain remote possibilities. 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 to diagnose or a misdiagnosis may result. Other diagnostic or therapeutic procedures such as, lab testing, medical treatment, x-ray and surgery are sometimes available. You may also choose no diagnostic studies and/or treatment. Your physician can discuss these options with you.

Brief Description of Endoscopic Procedures

1. **SEDATION AND ANALGESIA:** Administration of IV medications prior to and during the procedure to achieve a state of relaxation and comfort sufficient to improve tolerance for the procedure.
2. **EGD (esophagogastroduodenoscopy):** Examination of the esophagus, stomach and duodenum. Biopsies or polypectomy (removal of small growths called polyps) may be performed.
3. **ESOPHAGEAL DILATION:** Dilation (using dilating tubes or balloon dilators) may be performed to stretch narrow areas of the esophagus.
4. **ENTEROSCOPY:** Examination of the small intestine. Biopsies or polypectomy (removal of small growths called polyps) may be performed.
5. **FLEXIBLE SIGMOIDOSCOPY:** Examination of the anus, rectum and the left side of the colon. Occasionally the entire colon may be examined (colonoscopy). Biopsies or polypectomy (removal of small growths called polyps) may be performed.
6. **COLONOSCOPY:** Examination of all or a portion of the colon. Older patients and those with extensive diverticulitis are more prone to complications. Biopsies or polypectomy (removal of small growths called polyps) may be performed.
7. **COLON DILATION:** Dilation (using dilating tubes) may be performed to stretch narrow areas of the colon.
8. **ILEOSCOPY:** Examination of the lower portion of the small intestine (the ileum) through a person's ileostomy. Biopsies or polypectomy (removal of small growths called polyps) may be performed.
9. **POUCHOSCOPY:** Examination of the ileoanal pouch. Biopsies or polypectomy (removal of small growths called polyps) may be performed.

Nondiscrimination Policy: The Endoscopy Center [*GI Division Location*] does not discriminate against any person on the basis of race, gender, creed, color, national origin, handicap, age or sexual orientation in admission, treatment or participation in its programs, services or employment.

Disclosure of Ownership: The Endoscopy Center [*GI Division Location*] is owned entirely by the physicians who also perform the procedures. If you have any questions regarding this arrangement, please ask your physician or the administrator for further details.

Consent: I authorize the administration of medications as may be deemed advisable or necessary for my comfort, well-being, and safety. I consent to the taking and publication of any photographs made for the use in the advancement of medical education. I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed of the risks and possible complications of my procedure, and I have been given the opportunity to ask my physician any questions. I certify that information given by me as a patient regarding my history, problems, medications, food and fluid intake is correct. I also understand that a responsible adult must accompany me home when I am discharged from the Endoscopy Center. I understand that disregarding such advice could place me at risk if problems develop and go unreported. I hereby authorize and permit:

Physician Name: _____

And whomever he/she may delegate as his/her assistant to perform upon me the following:

Procedure: _____

If any unforeseen conditions arise during this procedure that call for (in the physician's judgment) additional procedures, treatment or operations, I authorize him/her to do whatever he/she deems advisable, including cardiopulmonary resuscitation and transfer to local hospital. I understand my advanced directive, if supplied to the center, will be sent to the hospital if I am transferred. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of this procedure.



INFORMED CONSENT FOR ANESTHESIA

I hereby authorize, consent and request [*anesthesia company name*] to perform the anesthesia deemed necessary for my procedure. I have been given an opportunity to have all my questions or concerns relating to my anesthesia care answered or addressed.

- Deep Sedation (TIVA with Propofol):** Drug injected into the blood stream producing unconsciousness. Patient may respond purposefully following repeated or painful stimulation. Spontaneous breathing is usually maintained. Cardiovascular function is usually maintained. Airway intervention may be necessary.
- MAC (Conscious Sedation):** Drug injected into the blood stream to produce sedation without loss of consciousness. Patient is able to respond purposefully to verbal commands. Spontaneous breathing is maintained. Cardiovascular function is usually maintained.

I have been informed and understand that there are occasionally side effects from anesthesia, including but not limited to some rare complications. I understand that in rare instances complications may require hospitalization to provide appropriate ongoing care.

Side Effects:

Sore throat
 Neck/Jaw pain
 Nausea and/or vomiting
 IV site pain or injury
 Dental injury
 Swelling
 Nosebleed

Rare Complications:

Adverse drug reaction
 Respiratory problems
 Aspiration
 Low blood pressure and/or heart rate
 Abnormal heart rhythm
 Paralysis
 Heart attack/stroke
 Death

I understand the importance of providing my healthcare providers with a complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol or any type of illegal drug may give rise to serious complications and must also be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service, and that I had ample time to ask questions and consider my decisions.

By signing this document, I hereby represent that I have been advised that certain anesthesia medications when administered in the first trimester or third trimester of pregnancy can be harmful to unborn children. I have been given an opportunity to clarify any questions relating to anesthesia and/or endoscopy during pregnancy, and all my questions have been answered to my satisfaction.

I further represent that I am not pregnant I am pregnant Not applicable

and I hereby give healthcare facility and [*anesthesia company name*] permission to perform colonoscopy/endoscopy in conjunction with anesthesia as deemed appropriate by my anesthesia provider.



SPECIALTY MEDICINE,
EXCEPTIONAL CARE

Advance Directive and Disclosures

The advance directive is a simple way to put your wishes about health care decisions in writing. It is a document in which you give instructions about your health care and what you want done or not done if you cannot speak for yourself. This document helps guide families and medical personnel in deciding the course of medical treatment to delay death. It usually spells out how aggressive medical treatment should be administered.

In Oregon, the Health Care Decision Act (ORS 127.505-127.995) allows an individual to name a person to direct your health care when you cannot do so. This person is called your “health care representative”. Your representative must agree to serve in this role and must sign the necessary forms.

The following are included within the advance directive:

- Living will
- Medical power of attorney
- Pre-hospital medical care directive

For further information on Advance Directives or downloadable forms:

- <http://www.oregon.gov/oha/PH/ABOUT/Pages/AdvancedDirectiveAdoptionCommittee.aspx>
- <http://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf>

Oregon Health Decisions at 1-800-422-4805

Completing an advance directive is completely voluntary. If you do not want an advance directive you do not need to complete the forms.

The Oregon Clinic’s Advanced Directive Policy

Life-sustaining efforts will be initiated and maintained on all patients who may have a cardiac/respiratory event while at the Endoscopy Center. Patients will be given the opportunity to be referred to another facility for their care if not in agreement with this statement of limitation. If available, copies of any advanced directives will accompany the patient being transferred to another facility.

PHYSICIAN DISCLOSURE

As required by Federal Medicare regulations we are required to disclose that our physicians have a financial interest in The Oregon Clinic’s Gastroenterology Endoscopy Centers.

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGMENT

In accordance with Oregon law (ORS 441.098), when you are referred for care outside of our clinic, we are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Patient Rights & Responsibilities

The “patient” refers to the patient, patient’s representative, or surrogate, if applicable.

AS A PATIENT OF THE OREGON CLINIC, YOU HAVE THE RIGHT TO:

- Receive all communications in a language and/or manner you understand. Interpreters will be provided when necessary. The Oregon Clinic provides aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters and language interpreters.
 - Information written in several of the common languages in this city.
 - If you believe that The Oregon Clinic has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex:
 - You can file a grievance with the Compliance Officer for The Oregon Clinic by mail at 541 NE 20th Ave, Suite 225, Portland, OR 97232; (fax) 503-935-8911; or email to compliance@orclinic.com.
 - You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at <https://www.hhs.gov/hipaa/filing-a-complaint/index.html> or by phone at 1-800-368-1019 (TDD) 800-537-7697. Complaint forms are available at <https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>; (fax) 202-619-3818.
 - For concerns about The Oregon Clinic's ambulatory surgical centers, contact the Oregon Health Authority, Health Care Regulation and Quality Improvement Program: 800 NE Oregon Street, Suite 465, Portland OR 97232; 971-673-0540.
- Considerate, respectful, and compassionate care in a safe and secure environment that is free of all forms of discrimination, abuse, or harassment. The Oregon Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Exercise your rights without being subjected to discrimination or reprisal.
- Personal privacy and confidentiality concerning your medical care. Information can only be released with your consent, except as provided by law. You have the right to be advised as to the reason for the presence of any individual. HIPAA regulations will be observed.
- Receive information about your diagnosis, treatment, and expected result from your provider or designated staff in terms you can understand. When it is medically inadvisable to provide such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Receive the necessary information and participate in decisions regarding a procedure or proposed treatment in order to give informed consent or to refuse this course of treatment.

- Reasonable continuity of care and to know, in advance, the time and location of appointment(s), as well as the practitioner providing the care.
- Consult with another physician or change providers if other qualified providers are available.
- Agree to or refuse to participate in research projects.
- Know the name and the professional status of the provider who has primary responsibility for coordination of your care and the names, professional relationships, and credentials of other practitioners and health care workers you may see.
- Within the confines of the law, review your medical records. All communications and records pertaining to your care will be treated as confidential.
- Receive information, in advance of a procedure, including a description of applicable State Health and Safety Laws, and if requested, official State advance directive forms. These are available upon request.
- Have in effect and documented on your medical record the presence of any Advance Directives concerning Living Wills, medical powers of attorney, or other documents that limit your care, and you have the right to be referred to an alternate facility if you wish to have your Advance Directives honored during your procedure. For further information, visit <https://www.oregon.gov/oha/PH/ABOUT/Pages/AdvanceDirectiveAdoptionCommittee.aspx>; Form: <https://www.oregon.gov/oha/ph/about/pages/adac-forms.aspx>
- Provide appropriate feedback, including suggestions and complaints.
- Voice grievances, verbally or written, regarding treatment or care that is, or fails to be, furnished. For assistance in expressing grievances or complaints verbally or in writing visit www.cms.hhs.gov/center/ombudsman.asp or 1-800-MEDICARE, Oregon DHS: <https://www.oregon.gov/DHS/ABOUTDHS/Pages/Gao.aspx>
- Examine and receive an explanation of your bill and our payment policies, regardless of the source of payment.
- After-hours access to physician owners via phone. Emergency measures are available as needed.

AS A PATIENT OF THE OREGON CLINIC, YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information about your health, including present condition, past illnesses, hospitalizations, medications, including over-the-counter products and supplements, allergies and sensitivities, and any other information that pertains to your health.
- Be an active participant in your care.
- Make it known whether you clearly comprehend a contemplated course of action and what is expected of you, including if you anticipate not following the prescribed treatment or are considering alternative therapies. Ask questions when you do not understand.
- Follow the treatment plan recommended by your practitioner, which may include the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable rules and regulations.
- Report unexpected changes in your condition to the responsible practitioner.
- Accept the responsibility for your actions if you refuse treatment or do not follow the practitioner's instructions.

- Provide complete and accurate billing information for claim processing and to pay bills in a timely manner.
- Keep appointments, be on time for your appointments, and notify your physician as soon as possible if you cannot keep your appointments.
- Behave respectfully toward others and respect their property while in The Oregon Clinic facilities. Failure to comply with this may lead to termination from the practice.
- Review our Privacy Policy: <https://www.oregonclinic.com/privacy-policy>

NOTICE OF REFERRAL RIGHTS

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside of our clinic, we, The Oregon Clinic, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time of the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
 - (a) That when referred, a patient has a choice about where to receive services; and
 - (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

To listen to a recording of this Patient Right and Responsibilities document, please call 503-935-8334.

(Revised 12/12/2023)



SPECIALTY MEDICINE, EXCEPTIONAL CARE

Billing Information

You will receive statements from separate entities associated with your procedure, such as the physician, facility (Oregon Clinic Endoscopy Center or hospital), anesthesia provider, pathologist, and/or (histology) laboratory. The Oregon Clinic Business Office (503-963-2900) can only provide you information associated with our fees. If you require assistance, or have any questions regarding your billing, please use the table below to determine who is best able to answer your questions.

Thank you for allowing us to provide your gastroenterology care.

SERVICES PROVIDED	Gastroenterology – East Locations: Gateway, Milwaukie and Vancouver, WA	Gastroenterology – West Location: Peterkort Building	Gastroenterology – South Locations: Tualatin, Oregon City and Newberg
Professional Fees: covers the GI physician professional services. Office Visits and Procedures	The Oregon Clinic Business Office Phone (503) 963-2900 Hours: M-F; 8:00am to 4:30pm		
Endoscopy Center Fees: covers facility usage, equipment, nursing care and medical supplies.			
Histology Fees: covers the cost of processing the specimen after a procedure.			
Pathology Fees: Covers the cost of the pathologist who reads and interprets the specimen slide.	Inform Diagnostics [Miraca/Cohen/Metroplex Pathology] Phone: (844) 290-5307 Hours: M-F; 7:00am to 6:00pm CST		
Anesthesia Fees: covers the professional fees from the MD or CRNA providing sedation.	Innovative Anesthesia (Practice Management Group-Billing Company) Phone: (888) 819-7818 Hours: M-F; 8:30am to 5:00pm EST	Innovative Anesthesia (Practice Management Group-Billing Company) Phone: (888) 819-7818 Hours: M-F; 8:30am to 5:00pm EST	Anesthesia Associates NW (Anesthesia Business Consultants-Billing Company) Phone: (877) 222-4217 or (925) 949-2302 Hours: M-F; 7:00am to 3:00pm PST
If your procedure was done at a hospital, please contact the hospital for ALL charges (professional, facility, anesthesiology and pathology fees).			
Any Providence Hospital	Providence Health and Services Business Office Phone: (503) 215-4300 Hours: M-F; 8:00am to 8:00pm, Saturday 9:00am to 2:00pm		
Any Legacy Hospital	Legacy Health System Business Office Phone: (503) 413-4048 Hours: M-F; 8:00am to 6:45pm		