

Advanced Gastroenterology of Bergen County, P.A.

Gastroenterology ♦ Hepatology ♦ Gastrointestinal Endoscopy

Richard K. Chessler, M.D.

Barry M. Zingler, M.D.

Mitchell K. Spinnell, M.D.

Michael E. Meininger, M.D.

Marc A. Fiorillo, M.D.

140 Sylvan Ave., Ste., 101A-101B
Englewood Cliffs, NJ 07632

Main Tel: 201-945-6564

Fax: 201-461-9038

Procedure Scheduling:
201-346-9912

Billing Inquiries:
201-461-5439

YOUR APPOINTMENT IS SCHEDULED FOR:

DATE: _____ TIME: _____

DR: _____ To Register

LOCATION: SSC&Z ENDOSCOPY CENTER STE., 101B

ATTENTION PATIENTS:

PLEASE READ THE ENTIRE CONTENTS OF THIS
PACKAGE AT LEAST **1** WEEK PRIOR TO YOUR
APPOINTMENT!!

FAILURE TO DO SO MAY RESULT IN
PROBLEMS WITH YOUR SCHEDULED
APPOINTMENT.

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Dear Patient:

You are scheduled to have an Endoscopic procedure in our S,S,C, & Z Endoscopy Center, located on the 1st floor at 140 Sylvan Avenue, Englewood Cliffs, New Jersey. There is a fee for the use of this facility as well as a separate fee for physician's services. **Please note that these procedures are not done in an office setting, but rather an certified ambulatory surgical center.** It is our suggestion that you verify with your insurance carrier whether or not you have any deductibles, copays, or co-insurances related to the use of this facility. Please be advised that the SSC&Z Endoscopy Center does not participate with all plans. We recommend that you call your insurance company to verify participation status. If the SSC&Z Endoscopy Center does not participate with your insurance plan, your out-of-network benefits (if applicable) will be utilized and you will be responsible for any deductibles as dictated by your plan.

In addition to the above fees there will also be a separate charge for any biopsies taken at the time of your procedure. These biopsies are sent to an independent laboratory for evaluation. These charges will be submitted to your insurance by the lab; however any charges not covered will be billed to you directly. If you receive a bill from the lab you must call them directly as our office has no control over their billing practices.

If you have a procedure performed at the S,S,C&Z Endoscopy Center, anesthesia will be provided to you by a physician who is a member of our practice. This physician is out-of-network for most insurance plans. Some plans will pay you, the patient, directly at which time we ask that you endorse that payment and send it to our office. **You will be responsible for any deductibles, copays, and co-insurances as dictated by your insurance plan.**

Although our gastroenterologists participate with most insurance carriers, it is impossible for our office to know every patient's individual coverage. Therefore, we urge you to contact your insurance carrier prior to your procedure to see exactly what your benefits are. You, as the patient are responsible to know and understand your insurance plan. You will be responsible for all copayments, deductibles, and co-insurances according to your insurance. Our staff will pre-certify your procedure and submit the claim to your insurance carrier, however we do not check your individual benefits.

If your procedure is strictly a screening procedure, please make sure to call your insurance to verify that you have coverage for this type of services. Screenings include procedures when you have no symptoms, but are, recommended based on age/or if you have a family history of cancer.

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Upon receiving this package, please notify our office of your primary insurance coverage and either mail or fax a copy of the front and back of your insurance card along with any referrals if applicable to the address or fax number to the left. **We must have these copies at least one week prior to your procedure.** If these are not received we will have no choice but to **CANCEL** your procedure. If you need to cancel your procedure we respectfully ask that you give at least 72 hours notice or there will be a \$150 cancellation fee. Failure to do any of the above may result in **YOU** being responsible for payment of the entire bill.

*I have read and fully understand the above information
and agree to pay accordingly.*

PRINTED

NAME: _____

SIGNED NAME: _____

DATE: _____

Please bring all Signed forms the day of the procedure

PATIENT RIGHTS AND RESPONSIBILITIES

SSC&Z Endoscopy Center

- I. The patient shall be informed verbally and in writing of his/her rights in advance of the date of the procedure, in terms that the patient can understand. A signature acknowledging receipt of verbal and written notification of these rights in advance of the day of the procedure will be obtained by the patient and or legal guardian and placed in the patient's chart as part of the permanent medical record.
- II. The patient will be informed of the services offered at the Surgery Center, the names of the professional staff and their professional status of who is providing and/or responsible for their care, including information on the facilities provisions for emergency and after hours and emergency care.
- III. The patient will be informed of the fees and related charges, including the payment, fee, deposit, and refund policy of the Surgery Center and any charges not covered by third-party payers or by the Surgery Center's basic rate.
- IV. The patient will be informed of other health care and educational institutions participating in the patient's treatment.
- V. The patient will be informed of the identity and the function of these institutions, and he/she has the right to refuse the use of such institutions.
- VI. The patient will be informed, in terms that the patient can understand, of his/her complete medical/health condition or diagnosis, the recommended treatment, treatment options, including the option of no treatment, risks of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, then the information will be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly will be documented in the patient's chart.
- VII. The patient will participate in the planning of his/her care, and has the right to refuse such care and medication. Upon refusal it will be documented in the patient's chart.
- VIII. The patient will be included in experimental care if the patient has agreed to such and gives written and informed consent to such treatment, or when a guardian has consented to such treatment. The patient also has the right to refuse such experimental treatment.
- IX. The patient has the right to voice grievances or recommend changes in policies and services to the Surgery Center personnel, the governing authority and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination, or reprisal.
- X. The patient will be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of the Surgery Center's personnel.
- XI. The patient will be assured of confidential treatment of information about him/herself. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another healthcare facility to which the patient was transferred requires that information, or unless the release of the information is required or permitted by law, a third party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.
- XII. The patient will receive courteous treatment, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
- XIII. The patient will not be required to work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules.
- XIV. The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.
- XV. The patient has the right to expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care.
- XVI. The patient has the right to information regarding credentialing of Health Care Professionals at the Center.
- XVII. The patient shall be informed verbally and by written notice in advance of the date of the procedure, of his/her physicians financial interest or ownership in the ASC; The signed copy of patient acknowledgement and notification of the physician financial interest or ownership will be placed in the patient's chart as part of the permanent medical record.
- XVIII. The patient shall be informed verbally and by written notice in advance of the date of the procedure, information on the ASC's policy on advance directives, including a description of applicable NJ health and safety laws and, if requested, official NJ advance directive forms. The signed copy of patient acknowledgement and notification of the ASC policy on advance directives will be placed in the patient's chart as part of the permanent medical record.
- XIX. The patient has the right to refuse any treatment, except as otherwise provided by law.

- XX. The patient will not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
- XXI. The patient has the right to change their provider if other qualified providers are available.
- XXII. The patient has the right to be informed about procedures for expressing suggestions, including complaints and grievances, including those regulated by state and federal regulations.
- XXIII. The patient has the right not to be misled by marketing or advertising regarding the competence and capabilities of the organization.
- XXIV. The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
- XXV. The patient has the right to receive care in a safe setting free from all forms of abuse and harassment.
- XXVI. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- XXVII. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- XXVIII. A patient is responsible for following the treatment plan recommended by the health care provider.
- XXIX. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- XXX. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- XXXI. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- XXXII. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
- XXXIII. A patient is responsible to provide complete and accurate information about his/her health, any medications, including herbals and over the counter supplements and any allergies or sensitivities
- XXXIV. A patient is responsible to follow the treatment plan prescribed by his/her provider.
- XXXV. A patient is responsible to provide a responsible adult to transport hi/her home from the facility and remain with him/her for 24 hours if required by his/her provider.
- XXXVI. A patient is responsible to inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care
- XXXVII. A patient is responsible to be respectful of all the health care providers and staff, as well as other patients.
- XXXVIII. The administrator will provide upon request to all patients and/or their families, the names, addresses, and telephone numbers of the following offices where complaints may be lodged:

Division of Health Facilities
 Evaluation and Licensing
 New Jersey Department of Health
 PO Box 367
 Trenton, NJ 08625-0367
 800-792-9770

State of New Jersey
 Office of the Ombudsman for the
 Institutionalized Elderly
 PO Box 808
 Trenton, NJ 08625-808
 609 943-4023
 877-582-6995 toll free

The administrator shall also provide all patients and/or their families, upon request, the names, addresses and telephone numbers of offices where information concerning Medicare and Medicaid coverage may be obtained

The website for the Medicare Ombudsman is: <http://www.cms.hhs.gov/center/ombudsman.asp> is available to the public and ASC patients to get information about the Medicare and Medicaid programs, prescription drug coverage, and how to coordinate Medicare benefits with other health insurance programs. The website also includes information about filing a grievance or complaint.

Addresses and telephone numbers contained in line 38 will be conspicuously posted throughout the facility, including, but not limited to, the admissions waiting room, the patient service area of the business office, and other public areas.

SSC & Z Endoscopy Center
140 Sylvan Ave., Suite 101A-101B
Englewood Cliffs, NJ 07632
201.945.6564 tel * 201-461-9038 fax

FACILITY CONSENT FORM

PATIENT'S NAME: _____ **DATE:** _____

PHYSICIAN'S NAME: _____

CONSENT FOR TREATMENT:

I, THE ABOVE-NAMED AND UNDERSIGNED PATIENT, GIVE MY CONSENT FOR CARE AT AND BY THE MEDICAL, NURSING ALLIED PROFESSIONAL STAFF OF THE ABOVE SURGICAL CENTER, WHICH MAY INCLUDE ROUTINE DIAGNOSTIC PROCEDURES AND SUCH MEDICAL TREATMENT AS MY DOCTOR OR HIS/HER DESIGNEES MAY FIND ARE NEEDED. I ACKNOWLEDGE THAT NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF ANY EXAMINATIONS, TREATMENTS OR PROCEDURES I MAY RECEIVE WHILE AT THE CENTER.

RELEASE OF MEDICAL RECORDS:

I AUTHORIZE THE CENTER TO RELEASE ALL OR ANY PART OF MY MEDICAL RECORD TO (A) HOSPITALS OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES, WORKERS' COMPENSATION CARRIERS, WELFARE FUNDS OR OTHER ORGANIZATIONS OR AGENCIES THAT MAY BE CONCERNED WITH THE PAYMENT OF COSTS RELATED TO MY TREATMENT AND (B) ANY OTHER ORGANIZATION OR AGENCY TO WHICH THE CENTER IS PERMITTED TO RELEASE SUCH INFORMATION UNDER APPLICABLE LAWS. IN THE EVENT I AM TRANSFERRED OR ADMITTED TO A HOSPITAL POST-OPERATIVELY, I AUTHORIZE THE CENTER TO OBTAIN A COPY OF THE HOSPITAL DISCHARGE SUMMARY.

FINANCIAL ARRANGEMENTS:

I AUTHORIZE AND DIRECT MY INSURER OR PAYOR TO PAY DIRECTLY TO THE ABOVE CENTER ANY OR ALL BENEFITS, UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT. I AGREE THAT, IN CONSIDERATION OF THE SERVICES THAT WERE PROVIDED TO ME, I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE AMOUNT PROMPTLY IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE FACILITY. I UNDERSTAND, THEREFORE, THAT TO THE EXTENT PERMITTED UNDER APPLICABLE LAWS AND CONTRACTUAL ARRANGEMENTS, I AM FINANCIALLY RESPONSIBLE TO THE CENTER FOR ANY AMOUNTS NOT COVERED BY INSURANCE. FURTHERMORE, I UNDERSTAND THAT MY INSURER OR PAYOR MAY REQUIRE CERTAIN HEALTH CARE SERVICES TO BE AUTHORIZED BEFORE THEY ARE FURNISHED TO ME. I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE CENTER WITH RESPECT TO THE SERVICES THAT I CHOOSE TO RECEIVE NOTWITHSTANDING THAT MY HEALTH INSURER OR PAYOR HAS REFUSE TO GIVE PREAUTHORIZATION FOR ALL OR ANY PORTION OF MY SERVICES.

PRE-CERTIFICATION:

YOUR INSURANCE COMPANY WILL BE CALLED TO PRE-CERTIFY YOUR PROCEDURE. PLEASE MAKE SURE THAT WE HAVE THE CORRECT INSURANCE INFORMATION. IT IS IMPORTANT TO NOTIFY US IF YOU HAVE DIFFERENT PLANS FOR PHYSICIAN AND HOSPITAL SERVICES.

I UNDERSTAND THAT THE REIMBURSEMENT MAY BE SENT TO ME INSTEAD OF THE CENTER. UPON RECEIPT OF THE INSURANCE PAYMENT, I WILL FORWARD THE CHECK AND THE EXPLANATION OF BENEFITS TO THE CENTER. IN ADDITION, I UNDERSTAND THAT MY INSURANCE PLAN MAY STILL HOLD ME RESPONSIBLE FOR A DEDUCTIBLE AND/OR COINSURANCE.

FACILITY CHARGE:

WHEN YOUR PROCEDURE IS PERFORMED AT THE ABOVE SURGICAL CENTER, THERE WILL BE A FACILITY FEE. THERE IS A CHARGE FOR THE USE OF THE SURGICAL SUITE FOR YOUR PROCEDURE. FEES WILL VARY ACCORDING TO THE TYPE OF PROCEDURE(S) THAT IS / ARE BEING PERFORMED. PATIENT RESPONSIBILITY IS DEPENDENT UPON INDIVIDUAL INSURANCE PLANS.

IF YOU HAVE ANY QUESTIONS REGARDING THE ABOVE INFORMATION, PLEASE SPEAK WITH THE ADMINISTRATOR.

COLLECTION EXPENSES: (MEDICARE/MEDICAID EXCLUDED)

SHOULD MY ACCOUNT WITH THE SURGERY CENTER BE REFERRED TO AN ATTORNEY OR OUTSIDE AGENCY FOR COLLECTION, I WILL PAY ALL REASONABLE COLLECTION EXPENSES (INCLUDING ATTORNEY'S FEES) ASSOCIATED WITH THE COLLECTION EFFORT. I ACKNOWLEDGE THAT ALL DELINQUENT ACCOUNTS WILL BEAR INTEREST AT THE LEGAL RATE.

OVER

ADDITIONAL CHARGES:

PROFESSIONAL FEES:

THESE ARE THE FEES THAT ARE BILLED BY YOUR PHYSICIAN FOR HIS SERVICES IN PERFORMING YOUR PROCEDURE. THESE FEES ARE WITHIN THE RANGE CONSIDERED USUAL AND CUSTOMARY FOR THIS AREA. PATIENT RESPONSIBILITY WILL VARY ACCORDING TO EACH INSURANCE PLAN.

FOR QUESTIONS PERTAINING TO YOUR PHYSICIAN'S BILL: PLEASE CONTACT YOUR SURGEON

ANESTHESIA:

A BOARD-CERTIFIED ANESTHESIOLOGIST WILL BE PARTICIPATING IN YOUR PROCEDURE IN ORDER TO PROVIDE COMFORT AND SAFETY. THIS SERVICE WILL BE BILLED TO YOUR INSURANCE COMPANY.

YOUR ANESTHESIA BILL: CONTACT OUR BILLING OFFICE AT 201-461-5439 DIRECTLY

QUESTIONS PERTAINING TO

BIOPSIES:

IF A BIOPSY IS REQUIRED DURING THE COURSE OF YOUR PROCEDURE, A TISSUE SAMPLE WILL BE SENT TO A LABORATORY TO BE ANALYZED BY A PATHOLOGIST. YOU MAY RECEIVE A SEPARATE BILL FROM THE PATHOLOGIST.

QUESTIONS PERTAINING TO YOUR PATHOLOGY BILL: CONTACT CBL PATHOLOGY AT 877-225-7284

HIPAA:

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY REGULATIONS.

PATIENT RIGHTS/ADVANCE DIRECTIVE/DISCLOSURE OF OWNERSHIP:

I HAVE BEEN PROVIDED IN ADVANCE OF THE DAY OF THE PROCEDURE WRITTEN AND VERBAL NOTIFICATION OF THE FOLLOWING:

- PATIENT RIGHTS & RESPONSIBILITIES.
- THE FACILITY POLICY ON ADVANCE DIRECTIVES
- DISCLOSURE OF OWNERSHIP (IF APPLICABLE)

ADVANCE DIRECTIVE/LIVING WILL:

- I HAVE AN ADVANCE DIRECTIVE OR LIVING WILL: YES NO
- I HAVE BROUGHT MY ADVANCE DIRECTIVE OR LIVING WILL WITH ME: YES NO

INFORMATION ON ADVANCE DIRECTIVES WAS OFFERED TO ME BY THE ASC

SSC & Z ENDOSCOPY CENTER DOES NOT HONOR DO NOT RESUSITATE DIRECTIVES.

CLOTHING AND VALUABLES:

I FULLY UNDERSTAND THAT THE CENTER IS NOT RESPONSIBLE FOR ANY PERSONAL PROPERTY (CLOTHING, EYEGASSES, DENTURES, ETC.) BROUGHT IN OR RETAINED IN THE LOCKERS AT ANY TIME. I FULLY UNDERSTAND THAT ANY VALUABLES (MONEY, JEWELRY, AND KEYS) SHOULD BE GIVEN TO A FAMILY MEMBER OR OTHER RESPONSIBLE PARTY FOR SAFE KEEPING.

ACKNOWLEDGEMENT OF DRIVING RISKS:

I HAVE BEEN INFORMED BY THE SURGERY CENTER THAT I SHOULD NOT DRIVE FOR AT LEAST 20 HOURS AFTER COMPLETION OF MY PROCEDURE. A RESPONSIBLE ADULT, UPON DISCHARGE FROM SSC & Z ENDOSCOPY CENTER, WILL ACCOMPANY ALL PATIENTS WHO HAVE RECEIVED GENERAL / INTRAVENOUS SEDATION / SPINAL / EPIDURAL ANESTHESIA. ALL PATIENTS WHO HAVE HAD LOCAL ANESTHESIA WITHOUT SEDATION, AND WHO MEET THE DISCHARGE CRITERIA MAY BE DISCHARGED UNESCORTED.

PATIENT SIGNATURE

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED TO HIM/HER, AND THE UNDERSIGNED IS SATISFIED THAT HE/SHE UNDERSTANDS ITS CONTENTS AND SIGNIFICANCE.

SIGNATURE OF PATIENT

DATE WITNESS

REPRESENTATIVE / GUARDIAN SIGNATURE

PATIENT IS A MINOR OR UNABLE TO SIGN BECAUSE:

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED, AND THE UNDERSIGNED IS SATISFIED THAT THE CONTENTS ARE UNDERSTOOD. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS BEEN DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S LEGAL REPRESENTATIVE OR GUARDIAN TO EXECUTE THE ABOVE AND ACCEPT ON BEHALF OF THE PATIENT.

SIGNATURE OF REPRESENTATIVE / LEGAL GUARDIAN

DATE WITNESS

ADVANCED GASTROENTEROLOGY OF BERGEN COUNTY, P.A.

Gastroenterology • Hepatology • Gastrointestinal Endoscopy

COLONOSCOPY INSTRUCTIONS FOR HALF-LYTELY PREPARATION

PLEASE READ THESE INSTRUCTIONS VERY CAREFULLY

YOU MUST HAVE SOMEONE DRIVE YOU, TO AND FROM THIS PROCEDURE DUE TO POSSIBLE EFFECTS OF ANESTHESIA

THIS FACILITY IS NOT LATEX-FREE. PLEASE INFORM US IMMEDIATELY IF YOU HAVE A LATEX ALLERGY!

If you are Diabetic and take medication for Diabetes, please discuss with your physician what diabetic medication you should take the day before and the day of your procedure.

SEVEN (7) DAYS PRIOR TO COLONOSCOPY

Please inform us ONLY if you are taking any blood thinning medication such as Aspirin, Coumadin, Plavix or any anti-inflammatory drugs such as Celebrex, Aleve or Motrin. They may need to be discontinued for up to 7 days prior to your exam. Do not stop any medications without consulting our office. Please discontinue Vitamin E and any Iron supplements 7 days prior to exam.

TWO (2) DAYS PRIOR TO COLONOSCOPY

Continue your regular diet, except for raw vegetables and fruit. You MAY eat cooked fruits and vegetables only.

DAY BEFORE COLONOSCOPY

On the morning prior to your exam add water to the fill line of your ½ gallon plastic jug of Half-Lytely. Shake vigorously to ensure that all the powder disintegrates. Put it in the refrigerator.

DO NOT eat solid food or non-clear liquids.

PLEASE DO NOT DRINK ANY RED OR PURPLE LIQUIDS !!

DRINK CLEAR LIQUIDS ONLY. CLEAR LIQUIDS INCLUDE:

FRUIT JUICES WITH NO PULP, WATER, TEA OR COFFEE (NO MILK, DAIRY OR SUGAR)
SODA—ANY FLAVOR

CHICKEN OR BEEF BROTH—NO NOODLES—JUST PLAIN BROTH ONLY!!

JELL-O —(NO RED OR PURPLE COLORS), ITALIAN ICES, HARD CANDIES

AT 12:00 P.M. (NOON) THE DAY BEFORE YOUR PROCEDURE

Please take the 2 Bisacodyl tablets that come with the Half-Lytely packet.

AT 6:00 P.M. THE NIGHT BEFORE YOUR PROCEDURE

Please start drinking the solution in the Half-Lytely container. Drink ONE (1), 8 ounce glass of the Half-Lytely solution every 10 to 15 minutes until the solution is finished.

BE SURE TO DRINK ALL THE SOLUTION

Once the Solution is finished, please drink at least another 32 oz. of water

DAY OF COLONOSCOPY

Do not have anything by mouth FOUR (4) hours prior to test ...NOT EVEN WATER.

You may brush your teeth that morning.

BLOOD PRESSURE MEDICATION IS OK TO TAKE. If it is within the 4 hour time frame PLEASE take your blood pressure medication with the smallest amount of water —just enough to swallow the medicine.