

Advanced Gastroenterology of Bergen County, P.A.

Gastroenterology ♦ Hepatology ♦ Gastrointestinal Endoscopy

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140 Sylvan Avenue.
Suite 101-A-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: _____
To Register

DR: _____

LOCATION: ENGLEWOOD HOSPITAL OUTPATIENT-REGISTRATION

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 at Englewood/Holy Name Hospital. 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 outpatient hospital setting. 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 outpatient facility and to verify participation status.

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 the hospital pathology 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.

At Englewood or Holy Name Hospital, anesthesia is administered by a group that is affiliated with the hospital. If you have any questions, you must call the hospital directly.

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 office 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 for screening purposes, please make sure to call your insurance to verify that you have coverage for this type of service. Screenings include procedures performed when you have no symptoms, but are, recommended based on age and / 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 our 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 this form signed the day of procedure

ADVANCED GASTROENTEROLOGY OF BERGEN COUNTY, P.A.

COLONOSCOPY WITH SUPREP

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

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

ONE DAY BEFORE THE PROCEDURE:

Have a **CLEAR** liquid diet throughout the day. Avoid ALL liquids that are **RED** or **PURPLE** in color such as red grape or cranberry juice. Avoid dairy products and juices with pulp such as orange and grapefruit juice.

SOUPS: Clear broth such as chicken, vegetable and beef or consommé

JUICES: white cranberry, white grape, apple, limeade, strained lemonade, orange

BEVERAGES: tea, coffee, sugar, Kool-aid, diet and regular soda (any flavor), vitamin water, Gatorade, sports drinks, and regular water

DESSERTS: water ices, Italian ices, popsicles, Jello any flavor—no red or purple

IT IS IMPORTANT YOU DRINK AS MUCH FLUID AS YOU CAN THROUGHOUT THE DAY!

Split-Dose Regimen:

FOR PROCEDURES SCHEDULED BETWEEN 7:00 A.M. AND 11:00 A.M.

FOLLOW THE SPLIT-DOSE REGIMEN AT 4:00 P.M. AND AGAIN AT 10:00 P.M.

FOR PROCEDURES SCHEDULED BETWEEN 11:30 A.M. AND 3:30 P.M.

FOLLOW THE SPLIT-DOSE REGIMEN AT 7:00 P.M. AND 5:00 A.M.

Pour ONE 6-ounce bottle of SUPREP liquid into the mixing container then add water to the 16-ounce line on the container.

Drink ALL the liquid in the container. You must drink two more 16-ounce containers of water over the next hour.

IT USUALLY TAKES ABOUT AN HOUR TO BEGIN TO HAVE A BOWEL MOVEMENT. YOU MAY NOTICE SOME BLOATING OR CRAMPING AT THE BEGINNING OF PREP, BUT THIS USUALLY, GRADUALLY, IMPROVES ONCE THE BOWEL MOVEMENT BEGINS.

YOU MAY CONTINUE TO DRINK CLEAR LIQUIDS UNTIL MIDNIGHT.

DAY OF PROCEDURE: **DO NOT EAT OR DRINK ANYTHING NOT EVEN WATER!!!!**

Please inform us **ONLY** if you are taking blood thinning medication such as Aspirin, Coumadin, Plavix or any anti-inflammatory drugs such as Celebrex, Aleve or Motrin. They may have 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.