SURGERY CENTER OF MELBOURNE
1401 S. Apollo Blvd., Suite B
Melbourne, Florida 32901
phone (321) 725-5151/fax (321) 725-5157

PACKET CONTENTS/INSTRUCTIONS

This packet of information and pre-procedure paperwork is being provided to you as our future patient. You have been given this packet because your doctor has scheduled an outpatient endoscopy procedure at our facility, and we want you to be able to focus on ***your health*** and ***your procedure*** rather than the paperwork on the day of your procedure. Please do not hesitate to contact any of the staff members at the Surgery Center of Melbourne if you have any questions, concerns or comments regarding this packet.

PLEASE ensure all instructions are followed and paperwork is completed, FAILURE to do so may result in the DELAY or CANCELLATION of your procedure.

Key Person Contact Information

Surgery Center of Melbourne
Jennifer O'Neill, RN
Center Director
Office Phone: (321) 725-5151 Option 6
Fax: (321) 725-5157
jennifer.oneill@amsurg.com (for any *clinical, medical*, or *anesthesia* questions requests, etc)

Surgery Center of Melbourne Billing Office Information
Stephanie Lorentz, *Office Manager, Billing Specialist*
Phone: (321) 725-5151 Option 4
slorentz@amsurg.com (any questions regarding your statements/invoices or how your procedure has been ***billed***)

Lori Lizotte, *Insurance Verification Specialist*
Phone: (321) 725-5151 Option 3
(***Benefit*** questions)

Katie Elam, *Scheduling Specialist*
Phone: (321) 725-5151 Option 2
(***Scheduling*** questions)

Jennifer Gault, *Front Office Operations Specialist*
Phone: (321) 725-5151 Option 1

Instructions for Completing Information/Returning Information to SCM

❑ Complete the enclosed **"Patient Self History"** form; use an additional sheet of paper if needed (do NOT write on the back of the form and do not use staples to attach), but include any health information that may not be asked or listed on the form. Sign and date the form at the bottom. **This form will need to be provided to the SCM at check-in on the day of your exam.**

❑ Complete the enclosed **"Patient MedicationHistory"** form and list any medication(s) you take either prescribed, over the counter, herbal or other. ***Do not leave any medication off the list,*** use an additional sheet of paper if needed (do NOT write on the back of the form and do not use staples to attach.) Sign and date the form at the bottom. **This form will need to be provided to the SCM at check-in on the day of your exam.**

❑ Read the enclosed **"Surgery Center of Melbourne Patient Billing/Financial Agreement"** document; complete, sign and date page 2 of this document. This is an important document regarding your responsibilities and the assignment of benefits (payment) by your insurance carrier(s) to the ***Surgery Center of Melbourne.*** **The completed/signed page 2 of this document (Verification/Receipt of Patient Billing/Financial Agreement) will need to be provided to SCM at check-in on your procedure date.)**

❑ For your convenience, you may **FAX** the above forms along with the signed HIPAA Privacy form, Patient Rights/Physician Ownership agreement and any Advance Directives and/or Power of Attorney to the SCM using the **enclosed confidential fax cover sheet.**

❑ **Review all other enclosed materials for your information; questions are welcomed. THANK YOU!!!**

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melbourne
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FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I authorize Surgery Center of Melbourne/ Amsurg Melbourne Anesthesia to transfer a credit to cover the balance in my Amsurg Melbourne Anesthesia/ Surgery Center of Melbourne account (this will not result in an additional charge to a credit card.)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Surgery Center of Melbourne, my admitting Physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physician who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by laws or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Surgery Center of Melbourne may have an ownership interest in Surgery Center of Melbourne. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Surgery Center of Melbourne.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCE DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to Advance Directives prior to the procedure. Information regarding Advance Directives, along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

Signature of Patient or Responsible Party

Print name

Relationship to Patient

Date Signed

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melbourne
1401 South Apollo Blvd Suite B
Melbourne, FL 32901
Phone: (321) 725-6151 Fax: (321) 725-6197

VERIFICATION/RECEIPT OF PATIENT BILLING/FINANCIAL AGREEMENT

Patient Name:_____
(last) (first) (middle initial)

Address:_____
Street Address/PO Box City State Zip Code

Cell Phone :_____ Home Phone:_____

Patient Email Address:_____May we send you health/billing info by email? Y N

Social Security Number:_____Date of Birth:_____Age:_____Gender: M F

Marital Status: Married Single Widowed Divorced Life Partner Legally Separated Other_____

Race: American Indian Alaskan Native Asian Black/African American White/Caucasian Native Hawaiian Pacific Islander Other_____ Unknown **Ethnicity:** Hispanic Non-Hispanic Unknown

Employer:_____ Employer's Phone#:_____

Primary Insurance:_____ Subscriber's Name :_____
(Policyholder)

Subscriber's Policy Number:_____Subscriber's Date of Birth:_____

Secondary Insurance:_____ Subscriber's Name:_____

Subscriber's Policy Number:_____Subscriber's Date of Birth:_____

Emergency Contact:_____
(Name) (Relationship) (Phone #)

My Driver for the day of procedure is:_____Phone#:_____
May we allow your driver into the recovery area with you (where your health care is discussed)? Y N
May we leave a message at your primary number if required? Y N
May we leave a message at your alternate number if required? Y N
May we speak to someone other than you regarding your healthcare and/or the billing process? Y N
Please list:_____

Patient Signature: _____ Date:_____

Verification of Patient signature by SCM Staff_____ Date: _____

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PATIENT SELF - HEALTH HISTORY

This is a CONFIDENTIAL form shared between you the patient, and your healthcare team; your complete disclosure is vital and appreciated. Please print. Thank You

SCHEDULED PROCEDURE (S) : ☐ COLONOSCOPY ☐ UPPER ENDOSCOPY ☐ SIGMOIDOSCOPY

Date of Procedure: _____ Time: _____ Doctor: _____

ANY Allergies: _____

Are you allergic to: Latex Y/N Eggs Y/N Sulfites (preservatives in wine/lunch meat) Y/N

Do you take Aspirin or Blood Thinners: ☐ Yes (circle: Aspirin Coumadin Plavix Other: _____) ☐ No

STOP Do not discontinue any medication without being directed to do so by your physician

HEART PROBLEMS:	YES	NO
Chest Pain/ Angina	☐	☐
Heart Attack	☐	☐
High Blood Pressure	☐	☐
Artificial Heart Valve	☐*	☐
Internal Defibrillator	☐*	☐
Pacemaker	☐*	☐
Cardiac Stents	☐*	☐
Irregular Heart Beat	☐	☐
Bacterial Endocarditis	☐*	☐
LUNGS:		
Asthma	☐	☐
Emphysema/TB	☐	☐
Smoking	☐	☐
Sleep Apnea	☐	☐
Anesthesia Problem?	☐*	☐
ENDOCRINE:		
Diabetes	☐	☐
Insulin?	☐	☐
Thyroid	☐	☐
MUSCLE/BONE/JOINT:		
Arthritis	☐	☐
Back Problem(s)	☐	☐
Neck Problem(s)	☐	☐
Implanted pins/rods etc?	☐*	☐
Within last year?	☐	☐
BRAIN:		
Stroke/TIA	☐	☐
Seizure Disorder	☐	☐
Head/Brain Injury	☐	☐
STOMACH/COLON:		
Ulcer	☐	☐
GERD/Reflux	☐	☐
Hiatal Hernia	☐	☐
History of Polyps	☐	☐
? Self or Family Member (circle)		
History of Colon Cancer	☐	☐
? Self or Family Member (circle)		

BLOOD PROBLEMS:	YES	NO
Anemia	☐	☐
Leukemia	☐	☐
Sickle Cell	☐	☐
Hemophilia	☐	☐
Recipient of Blood Transf.	☐	☐
Exposure to HIV/AIDS	☐	☐
LIVER DISEASE:		
Hepatitis	☐*	☐
Cirrhosis	☐	☐
Liver Failure/Transplant	☐*	☐
KIDNEY DISEASE:		
Dialysis	☐	☐
Kidney Stones	☐	☐
Difficulty voiding	☐	☐
Incontinence	☐	☐
Enlarged Prostate	☐	☐
GYN:		
Regular Menstrual Cycles	☐	☐
Possibly Pregnant	☐*	☐
Last Menstrual Cycle: _____		

SURGERIES (circle)

Tonsils	Gallbladder	Hernia
Appendix	Vasectomy	Tubal Ligation
Hysterectomy		C/Section(s)

Other: _____

Height: _____ Weight: _____

MISC HEALTH CONCERNS:

_____

_____

_____

Form Completed by: _____ Date: _____

Signature: _____

2024-05

PATIENT MEDICATION HISTORY

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This is a CONFIDENTIAL form shared between you the patient, and your healthcare team; your complete disclosure is vital and appreciated. Please print. Thank You

NAME: _____ PHYSICIAN: _____

The doctor doing your Endoscopy/ Colonoscopy/ Sigmoidoscopy at the Surgery Center of Melbourne will give you instructions regarding which medications to take the day of your procedure, which to discontinue before the procedure etc. Please call the physicians office if you are unsure of any medications and the need to take, discontinue or any other questions on medications.

Please: Do not discontinue any medication without being directed to do so by your physician!

Please list any medications you take on a regular basis, including herbal supplements, vitamins, over the counter medications (example: Tylenol, Motrin etc.) or check the box below if you do not take any medications, and sign at the bottom of this form.

☐ NONE: I take no medications on a regular basis

MEDICATION LIST

Medication Name	Dosage taken (mg, units, etc.)	Frequency (Example: 2 times a day, at bedtime, etc.)	Date last taken (To be completed by nurse on day of procedure)	INITIAL MEDS TO CONTINUE (To be completed by nurse on day of procedure

PATIENT SIGNATURE: _____ DATE: _____

SCM REVIEW: _____ DATE: _____

NURSE REVIEWED WITH PATIENT WHAT MEDICATIONS TO CONTINUE/DISCONTINUE UPON DISCHARGE.

PATIENTS SIGNATURE_____ DATE: _____

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Day of Procedure Checklist

☐ I have followed the **"nothing by mouth"** instructions from my physician's office (please keep in mind nothing by mouth includes even the tiniest amounts of liquids, foods, gum, and/or mints) and have completed the colon preparation (only if having a colonoscopy or sigmoidoscopy) as directed

☐ I have verified that I have a friend or family member acting as my driver to take me home after my procedure (please be aware that medical transport, taxis and public transportation are not a suitable transportation home)

☐ I have completed my pre-procedure paperwork and have either faxed it to the Surgery Center of Melbourne or I am hand carrying it (along with any advance directives I want the center to have on file) with me on the day of my procedure

☐ I have stopped any medications that my gastroenterologist has directed and I have taken any medication(s) I was instructed to take on the day of procedure with only the smallest sip of water needed to safely swallow the medication(s)

☐ I have warm socks with me to wear during my procedure

☐ I am wearing loose, non-constricting clothes that are easy to get on after my procedure/anesthesia and have removed all facial and genital piercings

☐ I have my photo identification, insurance card(s), and a payment source (check, cash, credit card-including CareCredit) with me to pay any co-insurance, co-pay, deductible, or cost-share that may be due at the time of my procedure or I have set up a payment plan prior to my procedure. I am prepared to make a separate anesthesia payment to Amsurg Melbourne Anesthesia, if required by my insurance

Upon Arrival at the Surgery Center of Melbourne

☐ I have checked in with the front office receptionist and provided her with my pre-procedure paperwork, insurance card(s), photo ID and payment for the facility and anesthesia (if due)

☐ I have received a receipt for any payment(s) I made

☐ I have received the copy of my signed *H2.6c Notice of Privacy Practices* and information regarding the center's Advance Directives Policy

☐ My driver is waiting in the lobby for me or has provided me with a phone number that I can provide the staff to reach him/her when I am in recovery and is within 15 minutes distance from the Surgery Center of Melbourne

SURGERY CENTER OF
melbourne

1401 SOUTH APOLLO BLVD., SUITE B

MELBOURNE, FL 32901

CONFIDENTIAL FACSIMILE TRANSMITTAL COVER-SHEET

TO: Surgery Center of Melbourne

PATIENT'S NAME:

SCM FAX NUMBER: (321) 725-5157

DATE OF PROCEDURE:

SCM PHONE NUMBER: (321)725-5151

TOTAL NO. OF PAGES, INCLUDING COVER:

RE: Pre-Procedure Paperwork

☉ DIRECT FOR IMMEDIATE STAFF REVIEW/PRE-PROCEDURE REVIEW

You may return the following completed documents by fax using this fax cover-sheet:
Patient Self-Health History
Patient Medication History
Verification/Receipt of Patient Billing/Financial Agreement
Patient Rights & Notification of Physician's Ownership
H2.6c Notice of Privacy Practices
Advanced Directives

Otherwise please bring them on your procedure date to the Surgery Center of Melbourne.

GENERAL AFTER PROCEDURE INFORMATION

For any endoscopic procedure, whether an upper endoscopy (EGD) or colonoscopy, any BLEEDING, CHEST PAIN, ABDOMINAL PAIN THAT IS NOT RELIEVED WITH PASSING GAS or BREATHING DIFFICULTY experienced after the procedure should be reported to your GI Physician immediately.
Your physician will visit you in the recovery area once your procedure is complete and answer any questions and provide you with his exam findings.
If any specimens are removed (polyps, biopsies etc) during your exam, the specimens are sent to a Pathologist for examination. The pathology results will be sent to your GI doctor as well as your family doctor within 10 business days. If you have not heard the results within 10 business days, please call your GI doctor's office for those results
If you have received sedation/anesthesia for your procedure, you may experience some light-headedness or dizziness for a few hours after your exam; please move and change positions slowly to avoid losing your balance
If you have received sedation/anesthesia for your procedure, you *must* avoid driving, operating any machinery, drinking any alcohol, taking any sleeping type medications and making important decisions until the next day. You may resume normal activities the next day (work, driving, etc).
You will receive instructions from the healthcare staff regarding medications after your procedure. Please be sure to ask if you have any specific questions
You are usually able to begin eating a regular diet soon after your procedure unless otherwise directed by your healthcare team. Start with a light, non-spicy meal to make sure your empty stomach will tolerate food, and then progress to whatever you would like to eat. DRINK AT LEAST 4-5 LARGE GLASSES OF A NON-CAFFEINE DRINK in addition to lots of other liquids after your procedure. RE-HYDRATION is extremely important.
If your IV site should be uncomfortable or sore after your discharge, please apply a cold compress on the day of your procedure for 15 minutes, three times that day. If the soreness persists the next day, apply a warm compress for 15 minutes three times a day. If the soreness/pain persist longer than the day after your procedure, or if your IV site becomes red or develops drainage, please notify your Physician right away.
During the first 48 hours after your procedure, please notify your GI Doctor immediately if you develop a fever of 101 degrees Fahrenheit or higher or if you develop chills with or without a fever, please notify your GI doctor immediately.

Colonoscopy Specific Information

The Doctor will introduce air into your colon during your exam; this air may remain in your colon after your exam and feels like "gas". You will be asked to "pass gas" in recovery; don't be hesitant! It is better out than in!!!

Upper Endoscopy Specific Information

It is not uncommon to have a "scratchy" throat after this exam. To help reduce the "scratchiness", gargle with warm salt water 2-3 x/day. Report it to your GI Doctor if it lasts more than 3 days.

Medications that can/may increase (extend) Bleeding

(Also known as "BLOOD THINNING" Medications).

Do Not discontinue or stop any medication *without* consulting your doctor. This list is meant as an informational tool, not a direction to stop blood thinning medications without your doctors' approval. This list is not meant to be all inclusive; please ask your doctor or healthcare team about any medications you take that are not found on this list, that may contain a blood thinning component.

Advil (Ibuprofen)
Advil Cold and Sinus Remedy (contains Ibuprofen)
Aggrenox
Aleve (Ibuprofen)
Alka-Seltzer (Contains Aspirin)
Aspirin
Bayer Select (Contains Ibuprofen)
Celebrex
Coumadin
Dimetap Sinus (Contains Ibuprofen)
Excedrin IB (Contains Ibuprofen)
Feldene
Heparin
Indocin
Indomethacin
Iron
Ketoprofen
Midol / Midol IB / Midol 200 (Contain Ibuprofen)
Mobic
Motrin (Ibuprofen)
Multi-Vitamins that contain Iron and/or Vitamin E
Naprosyn
Naproxyn / Naproxyn Sodium
Nuprin (Ibuprofen)
Pepto-Bismol (Contains Aspirin)
Plavix
Sine-Aid IB (Contains Ibuprofen)
St. John's Wort
Toradol
Ultram
Vioxx
Vitamin E
Voltaren / Voltaren Rapide / Voltaren SR