Gastroenterology Consultants of Long Island, PC

John M. Costable, M.D.,FACG *Ian M. Storch, D.O.,FACP,FACG*

2001 Marcus Avenue Ste. E240
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Phone (516) 673-4801
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May 21, 2020

Pre-Procedure Forms:

To minimize wait time, Please fill-out all started sections of this packet prior to coming in for your procedure. Thank you in advance.

GCLI

UNIVERSAL MEDICATION FORM

Name:		**Address:**	
Phone Number:		**Allergies:**	
Birth Date:			

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) Prescription and over-the-counter medications (examples: aspirin, antacids), herbals (examples: ginseng, gingko), and vitamins. Include medications taken as needed (example: nitroglycerin). Please also include if you received any injections recently, i.e. steroids. 2) CROSS OFF any medications you no longer take 3) Keep this card with you at all times. Show this card to every doctor visit on every visit, every visit to an emergency room and on admission to any hospital. 4) NEVER take drugs prescribed for someone else.

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: (How many times a day do you take this and when.)	Medication held due to procedure		Notes: Reason for taking / Doctor Name
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
New Medications added (don't forget injections; i.e. Cortisone or over the counter medications)					

OFFICE USE ONLY

Name of Medication in Office	Contra-indicated, Yes or No	
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No

PLEASE NOTE: This organization and its providers are not responsible for medications ordered by other organizations or providers. The above is a list of your medications provided to us by yourself or responsible adult.

✳ Patient Signature if applicable_____ Date_____

Responsible Adult Signature_____ Date_____

Signature of representative of organization accepting the patient_____ Date_____

Updated: (List all dates updated)

_____ _____
Patient/Guardian Signature Date

_____ _____
Organizational Representative Signature Date

_____ _____
Patient/Guardian Signature Date

_____ _____
Organizational Representative Signature Date

_____ _____
Patient/Guardian Signature Date

_____ _____
Organizational Representative Signature Date

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Patient/Guardian Signature Date

_____ _____
Organizational Representative Signature Date

_____ _____
Patient/Guardian Signature Date

_____ _____
Organizational Representative Signature Date

JOHN M. COSTABLE, M.D. IAN M STORCH, D.O.

Consent for Operative/Diagnostic Procedures Requiring Anesthesia or Sedation/Analgesia

✳—Patient Name: _____

Informed Consent to Endoscopic Exam

Direct visualization of the digestive tract and abdominal cavity with lighted instrument is referred to as a gastrointestinal Endoscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for, and possible risks of these procedures.

Explanation of procedure(s), risks, benefits and alternatives

Dr. John Costable / Dr. Ian Storch has fully explained to me the nature and purpose of the procedure(s) and has also informed me of expected benefits and complications (from known causes), attendant discomforts and the risks that may arise, as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

Principal Risk and Complication

1. Perforation: Injury to the digestive tract by the instrument which may result in punctures or tears of the lining with leakage of intestinal juices into body cavity. If this occurs, surgery to close the leak and/or drain the region is usually necessary.
2. Bleeding: if occurs, usually a complication of biopsy, polypectomy or dilatation. Management of this complication may consist only in careful observation or may require transfusion or possibly surgical operation for control.
3. Respiratory Depression: can occur due to sedation being used and/or an irregular heartbeat.
4. Other risk factors include drug reaction, complications from other associated disease which you may have such as a stroke or heart attack. Death, although extremely rare remains a remote possibility. You should inform you physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with a very low frequency. Your physician will discuss this frequency with you, if you desire with particular reference to you own indications for gastrointestinal Endoscopy. You must ask your physician if you have any unanswered questions about your test.

Alternative to Gastrointestinal Endoscopy

Although gastrointestinal Endoscopy is 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 of diagnosis or a misdiagnosis may result. There are other diagnostic or therapeutic procedures available which would include x-rays and surgery. Your physician will be happy to discuss these options with you if you so desire.

I consent to the taking and publication of any photographs in the course of the operation for the purpose of treatment and medical education.
I certify that I under stand the information regarding gastrointestinal Endoscopy and that I have been fully informed of the risks and possible complications thereof; I here by authorize and permit

Dr. John Costable / Dr. Ian Storch and whoever he may designate as his assistant to perform _____upon me the (insertion of a lighted tube through the large intestine) **with possible biopsy and polypectomy** (removal of a polyp). If any unforeseen condition arise during this procedure calling in his judgment for any additional procedures, operations, or medications. I further request and authorize him to do whatever he deems advisable. 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 results of this procedure.

✳ Patient Signature:_____ Date:_____
Patient or legally authorized person

Doctor: _____ Witness: _____

EAST SHORE ANESTHESIA, P.C.
ACCREDITED ENDOSCOPY OBS

CONSENT TO ADMINISTRATION OF ANESTHETICS

I, (patient name) _____, authorize (physician name) _____ and associates/assistants of his/her choice to perform Monitored Anesthesia Care (MAC), commonly called IV sedation, as a part of my upcoming surgery.

Additionally, I authorize the performance of any other procedures that in the judgment of Dr. _____ may be advisable for my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the operation or procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it, including the potential for serious harm. I understand the risks, complications and potential benefits of anesthesia; as well as potential problems associated with anesthesia during the recovery phase

Alternative methods of treatment, if any, have been explained to me along with their risks and benefits.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

_____
Today's Date

_____
Patient's Signature

_____
Witness

_____
Anesthesiologist/ Physician's Signature

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To All of Our Patients:

When a colonoscopy or an upper endoscopy is performed in our office, we would like you to be aware of how we bill your insurance company. There will be 5 separate bills submitted to your insurance company for re-imbursement for every procedure. The breakdown of the billing is as follows:

1. **Professional bill: for Dr. John Costable or Dr. Ian Storch for performing the procedure.**

2. **Facility bill: for the use of the procedure room and equipment.**

3. **Anesthesia bill: for the anesthesiologist Dr. Anil Patil.**

4. **Pathology bill: for the pathology lab to process the biopsies if any were taken.**

5. **Pathologist bill: for Dr. interpreting the processed biopsies from the lab.** *******Please note: If your current insurance is the Empire Government Plan and biopsies are taken you will be responsible for and additional copayment as required by your plan.***

Some of these bills may be processed using your out of network benefits causing the insurance company to make payment to you, the patient, directly. If you receive any payments directly you *must* mail us the check along with any paperwork received or simply bring it to our office so that we may apply the checks to the correct account. Failure to do so will result in you being responsible for the bill.

We hope this notice will help you to understand our billing process. If you have any questions regarding this please contact our office.

**** I have read the above notice and agree to its terms**

Date: _____

Patient Name _____

Patient Signature _____

Assignment of Insurance Benefits and Instruction for Direct Payment to Doctor

Name and address of Physician or Medical Provider:

GASTROENTEROLOGY CONSULTANTS OF LONG ISLAND, PC

In consideration of services rendered or to be rendered, I hereby assign to the service and/or his/her assignees my insurance benefits that are filed on my behalf, as shall equal the full amount of the bill for such services rendered in my name.

I hereby direct and instruct the _____ insurance company to pay by check made out and mailed to:

GASTROENTEROLOGY CONSULTANTS OF LONG ISLAND, PC
2001 Marcus Avenue- Ste 240E
New Hyde Park, NY 11042

Patient name:

C/O: Gastroenterology Consultants of Long Island, PC

Patient Adress:

Social Security Number:_____ Date of Birth: _____

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my Indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGIONAL.

I_____ authorize the release of any information pertinent to my claim to any insurance company adjuster or attorney with regard to this claim.

Dated _____

Signature of Policyholder _____Witness_____

Signature of Claimant if other than Policyholder (If Minor, Parent or Guardian)

_____

John M. Costable, M.D.,
Ian M. Storch, D.O.
Office: (516) 673-4801

DISCHARGE INSTRUCTIONS

Name _____ Date _____
Procedure performed _____
Other procedure performed _____
Biopsy _____ Polypectomy _____

ACTIVITY **The after-effects of the sedative drugs and medications you may have receive may cause you to feel weak, dizzy, sleepy, or somewhat confused. It is therefore important for at least 24 hours you observe the following restrictions:**

_____Do not drive or operate machinery or household appliances.
_____Do not smoke. Do not drink alcoholic beverages including beer or wine.
_____To the extent possible, defer from any important decisions.
_____Do not engage in exercise for at least 1 week if a polyp has been removed

DIET

_____Your first meal should be light: such as bland soup, cereal and/or toast, then resume:
_____normal diet _____low residue _____ high fiber _____ reflux diet _____gluten-free
_____If you had an EGD do not eat or drink for at least _____ hours at which time your gag reflex should have returned, and then you can start with liquids.

IV SITE

_____You may have some pain or swelling at the IV site. Apply a warm, wet compress to the area if you have discomfort. If symptoms persist, please contact us.

MEDICATIONS

_____**Do Not** take any aspirin products or other pain relievers for 10 days unless specifically instructed by your Doctor.
_____You make take acetaminophen (ie: Tylenol)
_____You may resume your regular medication _____Yes _____No
_____You have been given a prescription(s); use as instructed.

PROCEDURES

_____After colonoscopy/sigmoidoscopy _____After upper endoscopy
_____A small amount of blood in the stool is not uncommon. However, the passage of entire bloody bowel movement should be immediately reported.
_____Following a biopsy or removal of a polyp, bleeding may occur immediately. The risk of bleeding may still be present up to 2 weeks after your procedure.
_____If you have severe or persistent abdominal pain, fever, chills or any unusual situation report it to your doctor immediately. Call our office or utilize our emergency service by calling **(516) 987-9673**
_____If air was pumped into the gastrointestinal tract during the procedure, you may feel some discomfort which will usually subside after a few hours.
_____You may not have a bowel movement for 2-3 days.
_____If you experience any shortness of breath, chest pain, chills, or fever, contact your physician.
_____A sore throat is not uncommon after the procedure.

If for any reason you are unable to reach us and it is a medical emergency, please go to the nearest Emergency Room.

Patient may be discharged when discharge criteria is met _____.
Physician Signature

Acknowledgement of Receipt
I have received these instructions. I understand them and that I should call my doctor if any problems or questions arise at **(516) 673-4801.**

_____Witness

_____ Date

_____ Patient Signature

_____ Relationship