

**MOVI-PREP COLONOSCOPY**

**\*\*IMPORTANT BILLING INFORMATION YOU SHOULD READ\*\***

- ❖ When you have a colonoscopy at any outpatient facility you may receive up to 4 bills.
- ❖ Our office only handles billing for Dr.Nanavati. If you have any billing questions please call 239.593.9599 Ext 202 or 203.
- ❖ For Collier Endoscopy and Surgery Center please call 239.776.4856. (CESC not in-network w/ Aetna).
- ❖ For Anesthesia services please call 727.734.6932.
- ❖ For Pathology services call Naples Pathology 866.512.6639.

**\*\*\*It is your responsibility to be aware of terms and requirements of your insurance policy\*\*\***

- ❖ Please contact your insurance company to find out your cost for your services.
- ❖ The billing codes used for a screening colonoscopy is 45378 and a diagnostic colonoscopy is 45380.
- ❖ On the day of your procedure we will be collecting payment for your responsibility to the surgery center and for Dr. Nanavati. If you are paying by check you will need to bring two checks with you.
- ❖ We accept Visa, MasterCard, Discover, and American Express.

Payment in full for the patient responsible portion is expected at the time of service. **Any other arrangements must be made in advance.**

**THERE WILL BE A \$100.00 FEE FOR CANCELLED PROCEDURE WITHOUT 24-48 HOURS PRIOR NOTICE**

**\*\*\*\*\*IMPORTANT\*\*\*\*\***

**PLEASE COMPLETE AND RETURN LAST THREE PAGES ON THE DAY OF YOUR PROCEDURE!**

Advanced Gastroenterology of Naples, PA  
Shardul Nanavati, MD  
3439 Pine Ridge Road, Suite 301  
Naples, FL. 34109 (239) 593-9599

(Please read all instructions before starting prep)

**\*PLEASE arrive on \_\_\_\_\_ at \_\_\_\_\_ : \_\_\_\_\_ for your procedure\***

**PURCHASE AT PHARMACY:**

1. Fill prescription for MoviPrep. You **MUST COMPLETE** the **ENTIRE** prep to ensure the most effective cleansing.

**➤ DAY BEFORE PROCEDURE: \_\_\_\_\_**

**MORNING preparation**

1. You may eat a light breakfast. **DO NOT EAT ANY SOLID FOODS AFTER BREAKFAST.**
2. Begin a **CLEAR LIQUID DIET** for the remainder of the day IE: Gatorade, (BLACK) coffee, water, soda, broths, apple juice, etc...NO dairy, citrus, red/purple colored fluids.
3. Drink plenty of **CLEAR LIQUIDS** all day until midnight. You may eat Jell-O and/or popsicles until midnight.
4. You may take ALL of your normal medication EXCEPT Aspirin or any other prescribed blood thinners. If you are insulin dependent PLEASE follow attached medication instructions.

**EVENING preparation (Begin at 5PM FINISH by 7PM)**

1. Empty (1) pouch A and (1) pouch B into disposable container and fill with lukewarm water to the top line. Mix until dissolved.
2. The container is divided into 4 marks. Every 15 min. drink the solution down to the next mark until the container is empty. Follow with 16oz of **CLEAR LIQUID**.
3. Continue to drink plenty of fluids until midnight to AVOID dehydration.

**➤ DAY OF PROCEDURE: \_\_\_\_\_ (Between 4am-6am)**

**\*\*\*\*\* NOTHING BY MOUTH AFTER 6am NOTHING\*\*\*\*\***

1. Empty (1) pouch A and (1) pouch B into disposable container and fill with lukewarm water to the top line. Mix until dissolved.
2. The container is divided into 4 marks. Every 15 min. drink the solution down to the next mark until the container is empty. Follow with 16oz of **CLEAR LIQUID**.
3. **ONLY** take your blood pressure, heart, or breathing medication with a **SIP** of water. Any medication you think you should not stop please call office at 239-593-9599 and speak with a nurse.
4. You may use you scheduled daily inhaler and please bring it with you.
5. You may take the rest of your medications (as instructed by the doctor) after your procedure.

**\*\*\*\*\*IMPORTANT\*\*\*\*\***

- YOU WILL BE **REQUIRED** TO HAVE A DRIVER THE DAY OF THE PROCEDURE **NO DRIVING FOR 24 HOURS** AFTER PROCEDURE IT IS AGAINST THE LAW, YOU ARE CONSIDERED UNDER THE INFLUENCE.
- PLEASE LEAVE ALL VALUABLES AT HOME OR WITH YOUR DRIVER. **DO NOT WEAR CONTACTS (GLASSES ONLY PLEASE)**.
- AFTER YOU ARE CALLED BACK BY THE NURSE YOUR DRIVER WILL NEED TO RETURN IN APPROXIATLY 1 ½ HOURS. UNLESS OTHERWISE INSTRUCTED BY NURSE.

**\*\*\*Medication Instructions Prior To Your Procedure\*\*\***

**\*\*\*DO NOT TAKE YOUR INSULIN OR ORAL DIABETIC MEDICINE  
THE MORNING OF YOUR PROCEDURE\*\*\***

**1:** If you are diabetic and on insulin take half of your regular dose the day before procedure

**2:** If you are taking diabetic pills you may take them the day before your procedure.

**3:** If you are taking any of the following medications please stop taking them 5 days before your procedure. **UNLESS** specified by Dr. Nanavati.

**Plavix, Coumadin, Pradaxa, Aggrenox, Persantine, Dipyridamole, Aspirin, and non steriodals. IE: Alleve, Advil, Ibuprofen, ect.**

**\*\*\*Tylenol (Or Acetaminophen) is safe to take\*\*\***

**Please feel free to call our office if you have any questions.**

**Phone: 239-593-9599**

## Patient Disclosure and Billing Information

### Collier Endoscopy and Surgery Center

For our patients understanding, please be aware that there are multiple elements to your care provided at Collier Endoscopy and Surgery Center, Inc. Dr. Nanavati has ownership interest in the surgery center. You may also receive a bill or explanation of benefits from your insurance provider for Naples Pathology Associates, ALN Anesthesia, and the physicians practice (Dr. Keith Hussey, Dr. Shardul Nanavati, or Dr. Prathima Moorhty). If you have any billing questions please feel free to contact your insurance provider or the following numbers for more information.

#### **Advanced Directives Information:**

Advanced Directives policy information for Collier Endoscopy and Surgery Center may be provided on request. If you have executed an Advanced Directive, please provide us with a copy. Upon request we will be able to provide a copy of the official state Advanced Directive forms.

COLLIER ENDOSCOPY & SURGERY CENTER  
PATIENT INFORMATION

Legal Name: \_\_\_\_\_  
Last First M.I.

Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_ S.S. # \_\_\_\_\_

Sex: M F Marital Status: S M W D

Name of Spouse/S.O.: \_\_\_\_\_

Local Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Local Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_

Work #: \_\_\_\_\_

EMERGENCY CONTACT PERSON:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name of Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Cardiologist (if applicable): \_\_\_\_\_

MEDICARE & PPO: Assignment accepted. Deductible and/or co-payment payable at time of services.

PRIVATE INSURANCE: We will help file insurance. You are responsible for all charges not covered or paid for by Medicare and/or your insurance company.

*I hereby authorize Collier Endoscopy and Surgery Center to furnish necessary information to insurance carriers concerning my illness and treatments, and hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount of charges not covered or paid by Medicare and/or insurance. I have been informed by the center that Dr. Shardul Nanavati and Dr. Keith Hussey have an ownership interest in the above-referenced facility. I have been given the option to be treated at another facility and wish to be treated at the above-referenced facility.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**COLLIER ENDOSCOPY AND SURGERY CENTER  
MEDICATION RECONCILIATION**

**DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES?**

LATEX ALLERGY	
FOOD ALLERGY	
MEDICATION ALLERGY	

**CURRENT MEDICATIONS**

MEDICATION	DOSAGE	HOW TAKEN ORAL/INHLL/INJECT	HOW OFTEN	CONTINUE (MD USE ONLY)
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO
				YES OR NO

**NEW PERSCRIPTIONS (MD USE ONLY)**

MEDICATION	DOSAGE	HOW TAKEN	HOW OFTEN

**PAST SURGERIES / PROCEDURES**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NURSE'S SIGNATURE \_\_\_\_\_

~~COLLIER ENDOSCOPY AND SURGERY CENTER~~

3439 PINE RIDGE ROAD STE 301

NAPLES, FL 34109

239-594-5243 FAX 239-254-8435

**Providing quality care and safe endoscopic and pain management services to our patients. Owned and operated by Dr. Shardul Nanavati and Dr. Keith Hussey.**

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**ADVANCE DIRECTIVE/LIVING WILL**

I understand that Collier Endoscopy and Surgery Center's policy does not honor advance directives/living wills, but it is my right to have an advance directive/living will present in my medical record at Collier Endoscopy and Surgery Center. I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to the closest hospital, and provide that institution with a copy of such document and that at that time, the institution to which I have been transferred will make decisions about following any advance directive or living will.

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Signed

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Date

State information and forms to prepare an advance directive, if you decide to have one, can be found at the following website: [acha.myflorida.com](http://acha.myflorida.com) or by contacting:

Agency for Health Care Administration 2727 Mahan Drive, M.S. 16 Tallahassee, FL 32308  
1-888-419-3456

Filing Complaints: If you have a complaint against an ambulatory surgery center call the Customer Assistant Unit at 1-888-419-3456 or write to: Agency for Healthcare Administration Consumer Unit 2727 Mahan Drive, Bldg 1 Tallahassee, FL 32308

If you have a complaint against a health care professional and want to receive a complaint form call Consumer Services Unit at 1-888-419-3456 or write to: Agency for Health Care Administration Consumer Services Unit P.O. Box 14000 Tallahassee, FL 32317-4000

If you have a complaint and would like to contact The Joint Commission for the Accreditation of Healthcare organizations (TJC) do so by calling 1-800-994-6610

## SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

### Patient's rights:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given health care information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts Medicare.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of reasonable clear and understandable itemized bill and upon request, to have charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for experimental research purposes and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him/her and to the appropriate state licensing agency.

### Patient's responsibilities:

- A patient is responsible for providing to the health care provider, to the best of his/her knowledge, accurate and complete information about previous complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his/her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he/she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for his or her actions if he/she refuses treatment or does not follow health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care provider and health care facility rules and regulations affecting patient care and conduct.

Website for the Office of the Medicare Beneficiary Ombudsman: <http://www.cms.hhs.gov/ombudsman/resources.asp>  
The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help they need to understand their Medicare rights and protection

Signature/Date \_\_\_\_\_