Ventura Endoscopy Center Partners, LLC
5810 Ralston Street, Suite 101
Ventura, CA 93003
Ph: 805-650-5500; Fax: 805-650-5530

WELCOME TO VENTURA ENDOSCOPY CENTER

Business Hours Monday - Friday 6:30 am - 3:30 pm

Thank you for entrusting your endoscopy procedure to our facility. Our goal is to provide you with excellent service at all times. In the process of providing this service to you, please be aware that you may receive a phone call from our facility staff for the following reasons:

- To ensure readiness for the procedure
- To provide payment information
- To follow-up after your procedure

You may also receive a patient satisfactory survey via email or mailed to your home after your procedure date. This survey is very important to us and helps us continue to grow and provide the best care for our patients.

Packet Contents

1. Welcome to Ventura Endoscopy Center
2. Procedure Date/Time & Check-in List
3. Patient’s Rights and Responsibilities (Page 3 & 4)
4. Directions
5. Island View Gastroenterology Associates - Insurance Information on "Preventative" Procedures and Cancellation Policy
6. **CMS Regulations**
7. **Clinical Assessment and Past History**
8. **Disclosure of Physician Ownership – Pathology**
9. **Notice of Financial Interest and Responsibility**
10. **Outpatient Home Medication Review**

Please note: Bolded items above are forms that will require you to provide information and/or signatures. Please bring the bolded forms with you to your appointment at VEC.

Notice of Facility Policy Related to Advanced Directives:

An advanced directive tells your doctor what kind of care you would like if you become unable to make medical decisions because of accident, illness or mental incapacity. While we recognize and respect the rights of the patient to provide us with a copy of their Advanced Directive, it is our organization's policy not to honor these documents in this type of an outpatient setting. If a patient should have an emergency or otherwise become incapacitated at our facility, we will provide any and all necessary life-sustaining measures including immediate transport to the nearest acute care hospital for continued medical care. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

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PROCEDURE DATE/TIME & CHECK IN LIST

Please read instructions carefully and completely

PROCEDURE DATE:
CHECK IN TIME:
PROCEDURE TIME:

Things to Consider:

1. **If you receive any sedation, you must have an adult (18 years or older) who will pick you up following your procedure and take responsibility for you upon discharge. You will not be able to drive. We recommend you not take a taxi/ lyft/uber. You can only do so with an adult you know and trust to accompany you.**
2. The sedation that you will receive during your procedure will alter your ability to perform activities; including, but not limited to, the following: driving, operating equipment, conducting business and/or making important decisions. Therefore, you should refrain from such activities until the day after your procedure.
3. Please leave all jewelry and valuables at home. *(You will need to bring this paperwork, your glasses if needed to read the paperwork, your driver's license and your insurance card)*
4. You may resume normal activities the day after your procedure.
5. Any special instructions, including diet and medications, will be discussed with you following your procedure and prior to your discharge.

If you have any questions or concerns regarding the prep, the procedure, your medications, or, if you need to cancel, re-schedule or have any change in your insurance, please call your Gastroenterologist's office at (805) 641- 6525.

WHAT TO BRING THE DAY OF YOUR PROCEDURE:

If you have a medical power of attorney, they must be with you at your procedure and will need the MPOA paperwork with them for your procedure.

- ✓ Valid Driver's License or ID.
- ✓ Insurance Card(s)
- ✓ CO-PAY: Your co-pay is due by the date of service
- ✓ GLASSES: If needed for reading
- ✓ PAPERWORK: Items #6-10 of packet contents

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

Patients have:

1. The right to quality care and treatment given with respect, consideration, and dignity.
2. The right to appropriate privacy.
3. The right to the privacy of information regarding patient's diagnosis, treatment options, communication, and the potential outcomes of the treatment as well as access to information contained in his/her medical record.
4. The right to participate in decisions concerning care and treatment.
5. The right to know the physician performing his/her procedure may have financial interest or ownership in this ASC.
6. The right to be informed of patient responsibilities, conduct, and ASC rules affecting the patient's treatment.
7. The right to knowledge of services provided at this facility.
8. The right to discharge instructions, including information about after hours' care.
9. The right to detailed information regarding service fees and all charges.
10. The right to refuse participation in experimental research.
11. The right to receive the policy on advance directives and living wills in the facility and to be given information upon request.
12. The right to receive information on this ASC's nonparticipation in advanced directives.
13. The right to knowledge of the medical staff credentialing process, upon request.
14. The right to know the names of those treating the patient.
15. The right to truthful marketing or advertising utilized by the facility.
16. The right to be informed if the physician does not carry malpractice insurance.
17. The right to address a grievance.
18. The right to refuse a treatment, as permitted by law. One can refuse treatment and still receive alternate care.
19. The right to be fully informed regarding one's condition.
20. The right to understand and sign an Informed Consent form before receiving care
21. The right to appropriate assessment and management of pain.
22. The right to continuity of care. If overnight care is required, staff will arrange for transportation of a patient to the transfer hospital.
23. The right to respectful, safe care and treatment free from seclusion, restraints, abuse, and harassment.
24. The right to have a family member notified of his/her admission as well as notification of his/her personal physician, if requested by the patient.
25. The right to leave the facility against the advice of his/her physician.
26. The right to express spiritual and cultural beliefs.

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Patient Responsibilities

1. The patient is responsible for providing accurate/complete information related to his/her health; reporting perceived risks in his/her care, and for reporting unexpected changes in his/her health.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are to do.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. The patient is responsible for notifying the ASC office when unable to keep a scheduled appointment.
5. The patient is responsible for providing his/her healthcare insurance information, and assuring the financial obligations of his/her care are fulfilled as promptly as possible
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow the practitioner's instructions.
7. The patient is responsible for being respectful and considerate of other patients and organizational personnel.

These rights and responsibilities outline the basic concepts of service here at the Ambulatory Surgery Center. If you believe, at any time, our staff has not met one or more of the statements during your care here, please ask to speak to the Lead RN, Administrator/Director of Clinical Operations, or the Medical Director. We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

If you have a concern that cannot be addressed at the facility, please feel free to contact:

- Ventura Endoscopy Center- Administrator/Director of Clinical Operations at (805) 650-5500.
- Joint Commission Office of Quality Monitoring by email to: Report a Patient Safety Concern or File a Complaint | The Joint Commission, or by writing to: Joint Commission Office of Quality Monitoring, One Renaissance Boulevard, Oakbrook Terrace, IL 60181
- California Department of Public Health, Ventura District Administration: (800) 547-8267.
- Web site for the Office of the Medicare Beneficiary Ombudsman: Get help with your rights & protections | Medicare or Call 1-800-MEDICARE (1-800-633-4227) to get help. TTY users should call 1-877-486-2048. A representative can direct your inquiry to the Medicare Ombudsman as needed.

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DIRECTIONS TO VENTURA ENDOSCOPY CENTER

We are located at 5810 Ralston Street, Suite 101 in Ventura, CA 93003.
Please enter the facility from the parking lot located at the back of the building. (Next to the AAA building)

Travelling on 101 North:

1. Exit Victoria Avenue
2. Turn RIGHT onto Victoria. Avenue
3. Turn LEFT onto Ralston Street
4. Arrive at 5810 Ralston Street on your left

Travelling on 101 South:

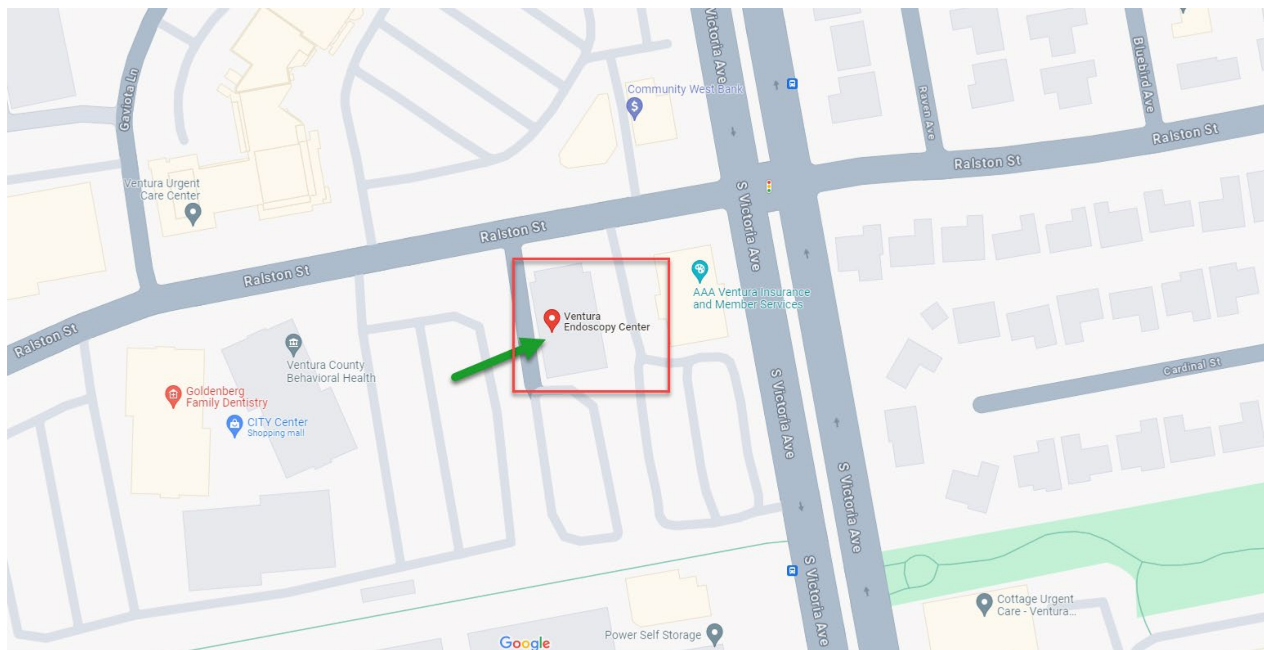
1. Exit Victoria Avenue and make a LEFT off the freeway
2. Turn LEFT on Victoria Avenue
3. Turn LEFT onto Ralston Street
4. Arrive at 5810 Ralston Street on your left

Travelling on 126 East:

1. Exit Victoria Avenue
2. Turn RIGHT onto Victoria Avenue
3. Turn RIGHT onto Ralston Street
4. Arrive at 5810 Ralston Street on your left

Travelling on 126 West:

1. Exit Victoria Avenue
2. Turn RIGHT onto Victoria Avenue
3. Turn RIGHT onto Ralston Street
4. Arrive at 5810 Ralston Street on your left



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ISLAND VIEW GASTROENTEROLOGY ASSOCIATES

Charles L. Menz, MD; Kip D. Lyche, MD;
Benito A. Pedraza, MD; Chetan V. Gondha, MD;
Joel A. Alpern, MD; Laya Nasrollah, MD; Tatyana Mitina, PA-C
168 N. Brent Street, Suite 404. Ventura, CA 93003
Telephone: (805) 641-6525 Fax: (805) 641-6530

Insurance Information

We appreciate you choosing us for your healthcare needs. Depending on the reason for your procedure, you may be responsible for a co-pay which may vary in amount from one insurance plan to another. **We recommend that you discuss and understand your coverage and benefits with your insurance company prior to your procedure**. **You can call the Customer Service Number on the back of your insurance card for this information.**

Please, if you have any questions or concerns you may discuss these issues with your doctor and/or a billing specialist in our office.

Cancellation Policy - 3 days (72 Hours)

You have been scheduled to have a procedure at Ventura Endoscopy Center. We have made arrangements at the facility to ensure that enough staff is present to provide a safe environment for your procedure. We have also allowed a specific time period for your procedure. **Due to these arrangements, which are usually made at least a week in advance, we ask that you please notify us at least 3 days (72 hours) in advance if you are unable to make it to the procedure appointment.** This will allow enough notice to your doctor and give us the opportunity to schedule another patient in this time slot.

IVGA has made the difficult decision to charge a **$50.00 cancellation fee if you cancel or re-schedule in less than 3 days (72 hours) of your assigned procedure appointment.** A **$100.00 fee will be applied if you fail to show up for your procedure appointment.** We understand that there may be an emergency entirely out of your control and the fee may be waived.

****Do not call Ventura Endoscopy Center to cancel or re-schedule your procedure****

Please call Island View Gastroenterology Associates at **(805) 641-6525** and ask to speak with your doctor's medical assistant.

Thank you for your cooperation.

Ventura Endoscopy Center
CMS Regulations

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This facility is a Medicare participating facility and under CMS Regulation §416.50 of the Conditions for Coverage we have a responsibility to inform you of your patient rights, advanced directives and financial interests of the physician prior to your procedure.

I, ___________________________, have been informed of the above mentioned information prior to my procedure which outlines the following:

1. Patient Rights and Responsibilities
2. Facility policy on Advanced Directives
3. Declaration of the physicians' ownership interests in the center
4. Disclosure of Physician Ownership – Pathology

(Signature)____

(Date)___ /____ / ____

This form must be placed in the patient's medical record upon completion.

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VENTURA ENDOSCOPY CENTER
CLINICAL ASSESSMENT AND PAST HISTORY

The information collected below is for confidential use by this facility only. Although this information may have been provided to your physician at the office we do not have access to that information and appreciate your assistance in completing this.

Date: ______________ Time: _____________ Primary Care Doctor____

What is the reason for your visit? ____

Name of responsible adult who will accompany you home today? ____________________ Contact # ______________________

May we discuss findings with the above person after your procedure as you may not remember due to sedation? **Y N**

Is this person your emergency contact? Y N

If no, please provide your emergency contact: Name____________________ Ph #____________ Relationship______________

Do you have any allergies? **Y N** ____

Please indicate YES or NO to ALL of the following questions:

Heart Disease or Heart Problems? ....Y N
High / Low Blood Pressure? (circle one)..........................Y N
Asthma/ Breathing Problems?..Y N
Do you use Inhalers? ....Y N
Did you use them today? ....Y N
Do you have sleep apnea? ....Y N
Do you have kidney disease? ....Y N
Do you have liver disease? ....Y N
Are you diabetic? ....Y N
Did you take your insulin today? ....Y N
Family history of colon cancer? ....Y N
Personal history of colon cancer? ....Y N
Do you have any bleeding problems? ....Y N
Do you have any pain now? ....Y N
Pain level (0-10) ___ Location: _____________
Do you have glaucoma/ eye disease? ....Y N
Have you had a stroke or other neurological issues? .... Y N
Do you have seizures or epilepsy? ....Y N
Do you have migraines/ severe headaches?...................Y N
Do you have any back/neck/spine problems?.................Y N
Any sudden unexplained weight loss, persistent cough or night sweats?..Y N
Do you have any immune diseases? ....Y N
Any skin problems/sores/rashes? ....Y N
Any possibility you are pregnant? ....Y N
(LMP-if applicable) ______________________
Are you currently breastfeeding? ....Y N
Are you currently the victim of abuse and want information about services available to you?..................Y N
Any anesthesia problems patient/family? ....Y N
Do you have an advanced directive? ....Y N

Do you have any religious or cultural beliefs we need to be aware of today?...Y N

Height: _____ ft. _____ in Weight: __________ lbs.

Have you had any previous surgery.................................Y N
(if yes, please indicate)

____

____

____

Do you have:
Pacemaker/Implant ....Y N
Do you have cards for this device? ....Y N
Dentures?...Y N
Hearing Aids? ....Y N
Glasses?...Y N
Do you use tobacco? ....Y N
Do you drink alcohol? ....Y N
Do you use recreational drugs?...Y N

Patient Signature: ________________________________

Nurse Verified Information: ________________________

Date: _________________ ***Time:*** ________________

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DISCLOSURE OF PHYSICIAN OWNERSHIP

IF YOU ARE AN HMO PATIENT YOU DO NOT NEED TO COMPLETE THIS FORM

Unless otherwise required by your insurance company, Ventura Endoscopy Center (VEC) sends pathology specimens to Inform Dx or to Island View Gastroenterology Associates (IVGA). Inform Dx or IVGA will process these specimens and produce slides (technical component).

These slides will be read by a Board-Certified Pathologist (professional component), Dr. Bui, who is contracted with IVGA. As a result of this arrangement, you may receive two bills for any pathology services performed, one for the technical component and one for the professional component. Dr. Bui's work will be billed through IVGA so his services will be in the same insurance network as your IVGA physicians.

IVGA is owned by Stephen Covington, MD; Charles Menz, MD; Kip Lyche, MD; Benito Pedraza, MD; Chetan Gondha, MD; Joel Alpern, MD; and Laya Nasrollah, MD.

You have the right to choose the provider of your health care services. Therefore, you have the option to use a pathology provider other than IVGA. If you would like a different arrangement, please indicate here:

____

You will not be treated differently by your physician if you choose to obtain pathology services from a provider other than IVGA and if you have any questions or concerns please feel free to ask the billing staff at IVGA or VEC.

If there are any issues with your pathology bills after services have been performed please contact the IVGA billing office at 805.641.6525, extension 1103.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in the pathology laboratory operations of IVGA.

__________________________ Signature of Patient	__________________________ Signature of Parent or Guardian (If applicable)
__________________________ Type or Print Name of Patient	__________________________ Type or Print Name of Parent or Guardian (If applicable)

Dated: ________________________