

Open Access Colonoscopy

Digestive Associates of Houston, PA now offers "Open Access Colonoscopy" to healthy patients who are eligible for colon cancer screening. In order to improve the convenience of the exam, a pre-procedure visit may no longer be required for some patients (with exceptions), saving patient time and effort.

STEP 1:

In order to schedule a screening colonoscopy, please download the "Open Access Colonoscopy Package" online.

After completing the forms, please fax them to 713-795-5254.

All the above information will be subject to review by our physician and insurance verification. Our office will contact the patient within 10 business days to schedule a colonoscopy appointment.

STEP 2:

Once our office contacts you to schedule your colonoscopy appointment, you can proceed with Step 2 to review the details of your appointment.

* **Preparation:** Please follow the Preparation Instruction for your colonoscopy. Alternate preparation is available, our office will instruct you the one that most suitable for your medical status.

* **Location:**

1. Texas International Endoscopy Center
6620 Main Street, Ste 1500, Houston, TX 77030
Tel: 713-520-8432
2. The O'Quinn Medical Tower at St. Luke's (formerly St. Luke's Medical Tower)
6624 Fannin Street, 9th Floor, Houston, TX 77030
Tel: 832-355-8177

* **What is Colonoscopy?** Please review for Patient Education.

STEP 1

In order to schedule a screening colonoscopy, please download the “Open Access Colonoscopy Package” online.

After completing the forms, please fax them to 713-795-5254.

All the above information will be subject to be reviewed by our physician and verification. Our office will contact the patient within 10 business days to schedule a colonoscopy appointment.

confidential
fax

To: Digestive Associates of Houston, PA

Attn: Lana

Fax Number: (713) 795-5254

Phone Number: (713) 795-4444

From: _____

Phone: _____

Pages: _____ (including this cover page)

Date: _____

Subject: **OPEN ACCESS COLONOSCOPY PACKAGE**

***Please send all the following forms:**

1. Copy of picture ID
2. Insurance card (front and back)
3. Medical History Checklist
4. Financial Policy
5. Patient Information Form
6. Screening Colonoscopy Form
7. Procedure Fees Explanation/Authorization Form

-
- This is my first time to have this procedure.
 This is a repeat procedure, last colonoscopy was done _____ years ago
by Dr. _____.

Appointment Preference:

<input type="checkbox"/> Mon	<input type="checkbox"/> AM	<input type="checkbox"/> PM
<input type="checkbox"/> Tue	<input type="checkbox"/> AM	<input type="checkbox"/> PM
<input type="checkbox"/> Wed	<input type="checkbox"/> AM	<input type="checkbox"/> PM
<input type="checkbox"/> Thur	<input type="checkbox"/> AM	<input type="checkbox"/> PM
<input type="checkbox"/> Fri	<input type="checkbox"/> AM	<input type="checkbox"/> PM

- First available
 No Preference

DIGESTIVE ASSOCIATES OF HOUSTON, PA
OPEN ACCESS COLONOSCOPY
MEDICAL HISTORY CHECKLIST

Today's date: _____

Patient's name (First name, Last Name): _____ Date of Birth: _____

Height: _____ Weight: _____ lbs Sex: M / F Daytime phone #: _____

Referring physician (if any): _____ My Pharmacy # is: _____

=====

PROVIDER: Isaac Rajjman, MD or Susana Escalante-Glorsky, MD

REASON FOR REFERRAL: _____

GASTROINTESTINAL HISTORY: (Please put the check mark(s) on the appropriate box below)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> FOOD GETTING STUCK | <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> PAIN WITH SWALLOWING |
| <input type="checkbox"/> GET FULL QUICKLY | <input type="checkbox"/> BLOATING | <input type="checkbox"/> HICCUPS | <input type="checkbox"/> DIFFICULTY SWALLOWING |
| <input type="checkbox"/> CHOKING | <input type="checkbox"/> FEVER | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> BELCHING |
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> WEIGHT GAIN | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> RECTAL BLEEDING |
| <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> BOWEL HABIT CHANGES |
| <input type="checkbox"/> BLACK STOOLS | <input type="checkbox"/> RECTAL PAIN | <input type="checkbox"/> OTHER: _____ | |
| <input type="checkbox"/> ALLERGIES | _____ | | |

PAST MEDICAL HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING? (Please put the check mark(s) on the appropriate box below)

- | | | | |
|---|---------------------------------------|--|---|
| 1. <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEART BYPASS | <input type="checkbox"/> HEART TRANSPLANT | <input type="checkbox"/> IRREGULAR HEARTBEAT |
| 2. <input type="checkbox"/> HAVE PACEMAKER OR IMPLANTED DEFIBILLATOR DEVICE | | | |
| 3. <input type="checkbox"/> HIGH BLOOD PRESSURE (BP) | | <input type="checkbox"/> TAKE MEDICATION FOR HIGH BP | |
| 4. <input type="checkbox"/> HAD STRESS TEST OR ANGIOGRAM | | | |
| 5. <input type="checkbox"/> HISTORY OF EMPHYSEMA | | <input type="checkbox"/> CHRONIC BRONCHITIS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> FREQUENT PNEUMONIAS | | <input type="checkbox"/> ASBESTOS LUNG | <input type="checkbox"/> TB |
| 6. <input type="checkbox"/> HISTORY OF KIDNEY DISEASE | | <input type="checkbox"/> ON DIALYSIS | <input type="checkbox"/> KIDNEY TRANSPLANT WHEN? |
| 7. <input type="checkbox"/> HISTORY OF LIVER DISEASE WHAT KIND? | | | |
| 8. <input type="checkbox"/> HISTORY OF BLEEDING DISORDER WHAT KIND? | | | |
| <input type="checkbox"/> EVER HAD BLOOD CLOT IN LUNG OR LEGS | | <input type="checkbox"/> LOW PLATELET COUNT | |
| 9. <input type="checkbox"/> HISTORY OF ANEMIA | | <input type="checkbox"/> BRUISE EASILY | <input type="checkbox"/> BLOOD TRANSFUSION WHEN ? |
| 10. <input type="checkbox"/> HAVE DIABETES | | <input type="checkbox"/> TAKE MEDICATIONS | <input type="checkbox"/> TAKE INSULIN |
| 11. <input type="checkbox"/> HAD SEIZURE | | <input type="checkbox"/> TAKE MEDICATIONS | |

- | | | |
|------------------------|--|--|
| ARE YOU ON..... | <input type="checkbox"/> ANY BLOOD THINNERS | <input type="checkbox"/> REQUIRE ABX BEFORE DENTAL/INVASIVE PROCEDURES |
| DO YOU USE..... | <input type="checkbox"/> USE OXYGEN DURING DAY OR NIGHT? | <input type="checkbox"/> SNORE LOUDLY WHEN ASLEEP? |

- PAST SURGICAL HISTORY:** ESOPHAGEAL SMALL BOWEL COLON PANCREAS
 GALLBLADDER LIVER OBESITY OTHER: _____

- SOCIAL HISTORY**
- SMOKING, HOW LONG? _____ HOW MUCH? _____
- ALCOHOL, HOW MUCH IN A WEEK? _____
- RECREATIONAL DRUGS, WHAT? _____
- WHAT IS YOUR OCCUPATION: _____

- FAMILY HISTORY**
- ANY CANCERS, WHAT KIND? _____ WHO? _____
- IBS IBD COLON POLYPS LIVER DZ ANEMIA

- HAVE YOU HAD A PREVIOUS ENDOSCOPY?**
- WHAT KIND? _____ WHEN? _____ RESULTS? _____

- CURRENT MEDICATIONS:** _____

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

Isaac Raijman, MD Susana Escalante-Glorsky, MD

Tel: 713-795-4444 Fax: 713-795-5254

FINANCIAL POLICY

Welcome to Digestive Associates of Houston, P.A (DAH) and thank you for choosing us! We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community and region, the following policies shall be enforced:

Self Pay/Non-Contracted Plans:

- All charges are due and payable at time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Patients with insurance:

- DAH will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay DAH for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90days from the date of service, both the insurance and patient portions of your account then become your responsibility. Our office policy is to automatically charge your credit card/personal check for any outstanding balance after your account becomes more than 90 days past due. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.
- It is the patient’s responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If you do not obtain a referral from your primary care physician prior to receiving services or a referral cannot be verified by our office, you have the option of re-scheduling your appointment. If you keep your appointment and/or receive services in our office, it is with the understanding that your health plan may not pay for charges related to the services provided by Digestive Associates of Houston, PA and that without a referral you will be responsible for payment of all charges.
- Pre-existing clause: If the patient has a current pre-existing clause in the policy, the patient is required to pay the full charge for the service being rendered instead of patient’s copay.

No-Show and Cancellation Policy:

- If the patient fails to cancel his/her procedure /test appointment at least 72 hours in advance, the patient is responsible for \$50 fee which will not be applied to any copay, deductible or coinsurance.

Delinquent / Unpaid Account:

- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent.
- Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physician’s established guidelines. Changes shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing.

Refunds:

- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients’ refunds will not be processed until all active or past due accounts are paid in full.

Third Party Litigation:

- Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.)

Insurance / Disability forms:

- There will be a \$25 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms and disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

Returned Checks:

- Checks returned to Digestive Associates of Houston, P.A. for insufficient funds, closed account, stopped payment, or for any other reason will be subject to \$50.00 fee.

Medical Record:

- A reasonable fee of \$25.00 shall be charged for the first twenty pages and \$0.15 per page for every copy thereafter. Requests will be completed within ten (10) business days.

I, the patient/patient’s legal representative, understand and agree to abide by the financial policy set forth.

Patient Name

Signature of Parent or Personal Representative

Date

Patient Information

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	DATE OF BIRTH	AGE	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK /CELL)
ADDRESS	SOCIAL SECURITY NUMBER		SEX (M or F)	MARITAL STATUS	
CITY, STATE, ZIP	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE		
EMPLOYER NAME & ADDRESS	OCCUPATION	E-MAIL ADDRESS			
REFERRING DOCTOR NAME, ADDRESS & TELEPHONE NO.					
PRIMARY CARE DOCTOR NAME , ADDRESS & TELEPHONE NO.					

Responsible Party *(if other than patient)*

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK /CELL)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F)	PATIENT'S RELATION TO RESP
EMPLOYER NAME & ADDRESS	OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance *(If you have Medicare and other insurance, please refer to Appendix A for reference.)*

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.	
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT	
INSURED'S EMPLOYER	INSURED'S OCCUPATION		
INSURANCE COMPANY NAME	INSURED'S ID #		
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #		
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT		

Secondary Insurance

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.	
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT	
INSURED'S EMPLOYER	INSURED'S OCCUPATION		
INSURANCE COMPANY NAME	INSURED'S ID #		
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #		
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT		

Authorization and Acknowledgement

AUTHORIZATION: I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. _____ Initials

ASSIGNMENT OF BENEFITS STATEMENT: I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred. _____ Initials

ACKNOWLEDGMENT OR RECEIPT OF PRIVACY NOTICE: I hereby acknowledge receipt of the Notice of Privacy Practices (attached) given to me by the above company. _____ Initials [] Consent refused by patient. Witness by: _____

Signature of Patient / Parent / Guardian / Insured

Printed Name

Date

DIGESTIVE ASSOCIATES OF HOUSTON, P.A.

Isaac Raijman, MD Susana Escalante-Glorsky, MD

Tel: (713) 795-4444 / Fax: (713) 795-5254

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
TO INDIVIDUALS**

I authorize Digestive Associates of Houston, PA (DAH) to disclose and release medical or other information to the below listed individuals. I understand that this includes, but is not limited to information related to treatment, diagnosis, billing or any health care operations performed at this facility.

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

I understand that all information requested will be provided to these individuals and I release DAH from all liability pertaining to the release of this information. I understand that this request can be changed at any time through a signed written request.

Printed Name of Patient Signature Date

SCREENING COLONOSCOPY

(Please sign this form only if you need to schedule a screening colonoscopy)

Patients who have screening examinations have no signs or symptoms, and have a set benefit from their insurance company. You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance policy will pay differently. The colonoscopy is no longer considered a screening procedure, it is considered a surgical procedure.

I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay and out-of-pocket expenses in the event that my scheduled screening examination does result in a procedure with a polyp or abnormality.

Signature of Patient/Parent/Guardian/Insured Printed Name Date

DIGESTIVE ASSOCIATES OF HOUSTON, PA

Isaac Rajjman, MD Susana Escalante-Glorsky, MD

6620 Main Street, Ste 1510, Houston, TX 77030

Tel: (713)795-4444 / Fax: (713)795-5254

**PROCEDURE FEES EXPLANATION / AUTHORIZATION FORM
(PHYSICIAN PROFESSIONAL FEE + FACILITY FEES)**

The purpose of this letter is to give you information about the financial responsibility for your procedure(s). Please understand that payment of your procedure(s) is part of the treatment plan and care.

Patient's Name: _____

Date of Birth: _____

1 Physician Professional Fee

Our practice will discuss with you in advance in regards to the estimated cost of physician professional fee for your procedure/test. Patients are responsible for any deductible and co-insurance amount which is due PRIOR to the procedure/test.

*** PLEASE NOTE: YOUR PAYMENT MUST BE RECEIVED PRIOR TO YOUR PROCEDURE DATE, OTHERWISE YOU WILL BE RESCHEDULED!**

This estimated physician professional fee is based upon our physician's present expectations of what procedure(s) will be required. We cannot be sure any additional procedure(s) will or will not be necessary.

It usually takes 30-45 days for the insurance company to pay the claim. After the insurance company pays us, we will either charge your credit card/check for any outstanding balance or refund any overpayment to patient's credit card or a refund check will be issued by our next billing cycle.

Please be aware of our No-Show and Cancellation Policy:

If the patient fails to cancel his/her procedure /test appointment at least 3 business days in advance, the patient is responsible for \$50 fee which will not be applied to any copay, deductible or coinsurance.

2 Facility Fees: anesthesiologist, pathologist and laboratory, etc.

You will likely receive separate bills from other healthcare providers for services that they provided while you were in the facility. Those bills are separate and apart from your physician professional fee. If you have questions about those bills, please call the number printed on their statements.

The Endoscopy may request a pre-treatment deposit, the amount of which depends on your coverage and deductible amount.

We strongly suggest that you monitor your account and the explanation of benefits forms that you received from your insurance. You should resolve all disputes involving patient portions and explanation of benefits directly with your insurance carrier.

AGREEMENT/AUTHORIZATION:

I HEREBY AUTHORIZE DIGESTIVE ASSOCIATES OF HOUSTON, PA TO CHARGE MY CREDIT CARD/CHECK FOR ANY OUTSTANDING BALANCES AND PATIENT PORTIONS OWED DIGESTIVE ASSOCIATES OF HOUSTON, AS PROVIDED IN THE FINANCIAL POLICY. I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

Credit Card#: _____ **Exp Date:** ____ / ____

Patient's Signature: _____ **Date:** _____

Witness by: _____ **Date:** _____

CHECK AUTHORIZATION:

Name or Company on check: _____

Address: _____

Bank Name: _____ **City / State:** _____

Check #: _____ **Routing#:** _____ **Account #:** _____

STEP 2

(Patient Copy)

Once our office contacts you to schedule your colonoscopy appointment, you can proceed with Step 2 to review the details of your appointment.

- * **Preparation:** Please follow the Preparation Instruction for your colonoscopy as closely as possible. There are two preparation instructions attached, our office will instruct you the one that most suitable for your medical status.

- * **Location:**
 1. Texas International Endoscopy Center
6620 Main Street, Ste 1500, Houston, TX 77030
Tel: 713-520-8432

 2. The O'Quinn Medical Tower at St. Luke's (formerly St. Luke's Medical Tower)
6624 Fannin Street, 9th Floor, Houston, TX 77030
Tel: 832-355-8177

- * **What is Colonoscopy?** Please review for Patient Education.

COLONOSCOPY PREPARATION WITH OSMO-PREP® TABLETS

The following are the instructions that you will need to follow prior to your colonoscopy. Please try to follow them as closely as possible to ensure a successful procedure. It is possible that you may feel abdominal cramping, rectal discomfort, some rectal bleeding, tiredness, and headaches during the preparation. Should any of these symptoms be significant or you have concerns about them, please do not hesitate to contact us at 713-795-4444. **Failure to take this preparation as indicated below may result in a poorly cleansed colon and possible cancellation of the procedure.**

You will need:

- Prescription for 32 tablets of **Osmo-Prep®**
 - 4 tablets of **Dulcolax®** (bisacodyl) - available over-the-counter at any drug/grocery store.
- At least **5** days ahead, stop Aspirin, Advil, Aleve, Celebrex Ibuprofen, Lovinox, Motrin, any iron pills or medications that contain iron. You may take Tylenol if it is necessary.
 - At least **3** days ahead, stop Plavix and Coumadin.
 - Let us know if you are taking blood thinners.

ONE DAY before your procedure:

- Start on a **CLEAR** liquid diet and continue clear liquids throughout the day. **Solid foods, milk, or milk product are NOT allowed!!!**
- **Clear Liquids include:** Water, Jell-O (not the red or purple kind), apple juice, white grape juice, clear broth, soda (any, but **NO** cream sodas), bouillon, coffee without cream (sugar is OK), tea, popsicles, **NO** alcohol!!

Follow this regimen:

At **4 PM**, start taking **Osmo-Prep®** tablets EVERY 15 MINUTES with at least 8 ounces of any clear liquid.

4:00 p.m.:	4 tablets	with 8 oz. of clear liquid
4:15 p.m.:	4 tablets	with 8 oz. of clear liquid
4:30 p.m.:	4 tablets	with 8 oz. of clear liquid
4:45 p.m.:	4 tablets	with 8 oz. of clear liquid
5:00 p.m.:	4 tablets	with 8 oz of clear liquid

=====

TOTAL = 20 tablets

THE DAY of your procedure:

- 3 to 5 hours prior to the procedure, take 4 tablets (total = 12 tablets) every 15 minutes with 8 oz. of clear liquid.
- Take 4 tablets of Dulcolax (generic: Bisacodyl) with 8 ounces of any clear liquid
- Nothing by mouth after finished taking the tablets with clear liquid.
- If you normally take medications in the morning, take them on the day of the procedure with a small sip of water.
- Insulin should not be taken on the morning of your procedure.
- Please remember to bring a responsible adult to accompany you home after the procedure. You will **NOT** be allowed to drive as you will be sedated for the procedure.
- Please bring your current insurance card(s) and any papers your doctor has given you, such as laboratory test reports and radiological reports.

Results: The medical assistant will notify you in the mail regarding your biopsy result (if taken) within 10 business days.

<i>Dr. Raijman's medical assistant:</i>	<i>Natalia: (713)795-4444 * 103</i>
<i>Dr. Escalante's medical assistant:</i>	<i>Daicy: (713) 795-4444 *110</i>
<i>Open Access Scheduler:</i>	<i>Lana: (713)795-4444 * 101</i>

If you would like to send us email, please request your web account by visiting: www.dahpa.com, go to Welcome Package tab and click my medical portfolio to request web account ID and PW.

We appreciate your efforts in helping us to help you
All of us at Digestive Associates of Houston, P.A. thank you and wish you well

COLONOSCOPY PREPARATION WITH MOVIPREP

The following are the instructions that you will need to follow prior to your colonoscopy. Please try to follow them as closely as possible to ensure a successful procedure. It is possible that you may feel abdominal cramping, rectal discomfort, some rectal bleeding, tiredness, and headaches during the preparation. Should any of these symptoms be significant or you have concerns about them, please do not hesitate to contact us at 713-795-4444. **Failure to take this preparation as indicated below may result in a poorly cleansed colon and possible cancellation of the procedure.**

FIVE DAYS BEFORE PROCEDURE:

Do not take any blood thinners such as (Aspirin, NSAID's, Plavix, Coumadin, Warfarin) during the 5 days preceding your procedure UNLESS instructed otherwise.

THE DAY BEFORE YOUR PROCEDURE:

1. Your **MoviPrep** comes with 2 clear packets of prep solution. For your first dose, open 1 of the clear packets and pour the A pouch and the B pouch of **MoviPrep** in the container provided. Fill with water to the fill line and **refrigerate**. Do this early in the morning so the prep will be cold when you begin drinking it.
2. Stay on a **clear liquid diet** all day THE DAY BEFORE YOUR PROCEDURE. This includes water, black coffee (no cream), tea, lemon or lime Jello (no fruit), chicken or beef broth, apple juice, ginger ale, 7-Up, Sprite, ice pops, diet sodas (diet Coke Diet Pepsi, Diet Dr. Pepper), and clear Gatorade. Sweetners such as Sweet&Low, Equal, and sugar are ok. **NO RED OR PURPLE BEVERAGES OR JELLO.**
3. Begin drinking MoviPrep at **6:00pm**. Drink 8 oz. every 10-15 min. until it is all gone. Once you have completed drinking the MoviPrep solution, drink (2) 8 oz glasses of clear liquid. This will keep you hydrated.
4. As soon as you have completed drinking the first dose, mix the second dose. Open the remaining clear packet and pour the A pouch and the B pouch of **MoviPrep** in the same container provided. Fill with water to the fill line and **refrigerate**. You will drink this second dose the day of your colonoscopy.
5. **At midnight you can no longer have anything to eat or drink** other than the prep until after the procedure.

THE DAY OF YOUR PROCEDURE:

6. Begin drinking the MoviPrep you mixed the night before **4 hours prior to your scheduled procedure time**. (example: if your colonoscopy is at 9am, you will need to begin drinking your MoviPrep at 5am) Drink 8 oz. every 10-15 min. until it is all gone. Once you have completed drinking the MoviPrep solution, drink (2) 8 oz glasses of clear liquid. This will keep you hydrated.
7. You may take important medications (such as heart, blood pressure, thyroid or a seizure disorder etc.) with a small sip of water on the morning of your procedure. If you are a **diabetic**, DO NOT take your diabetic medications on the morning of your procedure. Routine medications with the exception of blood thinning medications may be taken when you get home.
8. **Transportation:** Since a colonoscopy involves some anesthesia/sedation, you **MUST** have someone drive you home and stay with you during the following 4-6 hours (NO TAXI DRIVERS). They should also remain in the clinic during your procedure so the physician may speak with them once you are in recovery.
9. TIP: Using A&D ointment, Vaseline or diaper rash ointment between bowel movements will help prevent rectal irritation. You can also use baby wipes in place of toilet tissue.

Results: The medical assistant will notify you in the mail regarding your biopsy result (if taken) within 10 business days.

Dr. Raijman's medical assistant:
Dr. Escalante's medical assistant:
Open Access Scheduler:

*Natalia: (713)795-4444 * 103*
*Daicy: (713) 795-4444 *110*
*Lana: (713)795-4444 * 101*

If you would like to send us email, please request your web account by visiting: www.dahpa.com, go to Welcome Package tab and click my medical portfolio to request web account ID and PW.

We appreciate your efforts in helping us to help you.
All of us at Digestive Associates of Houston, P.A. thank you and wish you well.

DIGESTIVE ASSOCIATES OF HOUSTON, PA

Isaac Rajjman, MD Susana Escalante-Glorsky, MD

Tel: 713-795-4444 Fax: 713-795-5254

www.dahpa.com

ENDOSCOPY CENTERS

Our office will contact you to schedule your procedure, you can use this form to remind you the information that you need for your procedure.

Procedure Date: _____
Check-in Time: _____

We are affiliated with the following Outpatient Endoscopy Centers: (Please circle the one when we schedule your appointment)



1. TEXAS INTERNATIONAL ENDOSCOPY CENTER

6620 Main Street (Baylor Clinic Bldg)
Ste 1500
Houston, TX 77030
Tel: 713-520-8432

* *Valet parking is available at the Main Street entrance*

* *The entrance to the parking garage is located on Southgate.*



2. THE O'QUINN MEDICAL TOWER AT ST.LUKE'S (FORMELY ST. LUKE'S MEDICAL TOWER)

6624 Fannin Street
9th Floor
Houston, TX 77030
Tel: 832-355-8177

* *Take the elevator near the Security desk and go to the 9th floor.*

* *Check in with the receptionist at the desk in the waiting area.*

**** Please bring your current insurance cards and any papers your doctor has given you, such as laboratory test reports, x-ray and CT scan reports.**

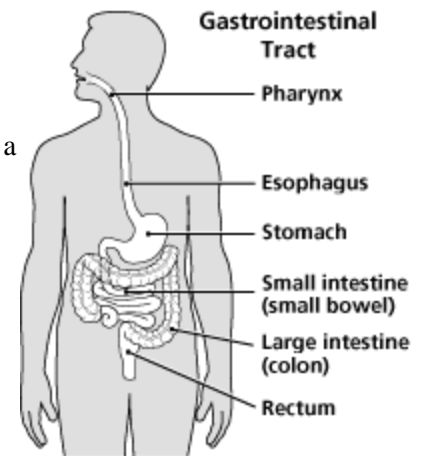
What is Colonoscopy?

What is a colonoscopy?

Colonoscopy is an outpatient procedure in which the rectum and the inside of the lower large intestine (colon) are examined. Colonoscopies are commonly used to evaluate bowel disorders, rectal bleeding or polyps (usually benign growths) found on contrast x-rays. Colonoscopies are also performed to screen people over age 50 for colon and rectal cancer.

What happens during a colonoscopy?

During a colonoscopy, a physician uses a colonoscope (a long, flexible instrument about 1/2 inch in diameter) to view the lining of the colon. The colonoscope is inserted through the rectum and advanced to the large intestine. If necessary during a colonoscopy, small amounts of tissue can be removed for analysis (called a biopsy) and polyps can be identified and removed. In many cases, colonoscopy allows accurate diagnosis and treatment without the need for a major operation.



Bowel preparation

The bowel must be clean in order for colonoscopy to be successful. It is very important that you read and follow the instructions given to you for your bowel preparation well in advance of the test.

On the day of the procedure

A physician will explain the procedure in detail, including possible complications and side effects. The physician will also answer any questions you may have.

During the procedure

- The procedure is performed by a physician experienced in colonoscopy.
- You are asked to wear a hospital gown and remove eyeglasses.
- You are given a pain reliever and a sedative intravenously (in your vein). You will feel relaxed and drowsy.
- You will lie on your left side, with your knees drawn up.
- The colonoscope is inserted through the rectum and advanced to the large intestine.
- A small amount of air is used to expand the colon so the physician can see the colon walls.
- You may feel mild cramping during the procedure. Cramping can be reduced by taking slow, deep breaths.
- The colonoscope is slowly withdrawn while the lining of your bowel is carefully examined.
- The procedure lasts about 30 minutes.

What happens if a polyp is discovered?

If a polyp is discovered, a thin snare wire is passed through the colonoscopy and the polyp is encircled. The snare is tightened and an electric current is passed through the wire which cuts off the polyp. The polyp is then brought out of the colon and sent to the pathologist for further examination.

Are there any possible complications?

The possible complications of colonoscopy and polypectomy (polyp removal) include perforation (rupture) of colon, hemorrhage from the colon and side effects due to the medicines (sedatives) which are given. In very rare circumstance, death could result from a complication.

After the procedure

- You will stay in a recovery room for about 30 minutes for observation.
- You may feel some cramping or a sensation of having gas, but this usually passes quickly.
- A responsible adult must accompany you home. Do not drive or operate machinery for at least 8 hours after the procedure.
- You may resume your normal diet.
- If a biopsy was taken, you may notice light rectal bleeding for 1 to 2 days after the procedure. This is normal.