GREATER HOUSTON DIGESTIVE DISEASE CONSULTANTS
9200 Pinecroft Drive Suite 480 • The Woodlands, TX 77380
Phone: 281.205.1111 • Fax: 281.419.2111 • www.GreaterHoustonDDC.com

PATIENT REGISTRATION AND CONSENT FORMS

PATIENT INFORMATION

Last Name_____ **First Name:** _____**Middle Initial**: _____

Street Address:_____ **Apt#** _____ **City:** _____ **State:** _____ **Zip:**_____

Date of Birth: _____ **Sex**: ☐Male ☐Female **Social Security #** _____**Marital Status**: _____

Race: ☐American Indian /Native Alaskan ☐Asian ☐Black /African American ☐Hispanic /Latino ☐Native Hawaiian /Pacific Islander ☐White ☐Other

Cellphone :(_____)_____**Home Phone:** (___ __)_____ **Work Phone** :(_____)_____

Email Address: _____ **Emergency Contact:** _____**Contact Number** _____

Referring Doctor: _____**Primary Care Doctor:** _____**Employer (or School if student):** _____

LOCAL PHARMACY /PHONE NUMBER _____

HIPPA COMMUNICAITION PREFERENCE

In order for our office to better communicate with you, please indicate your preferences below:

What is your primary phone contact? ☐Cell Phone ☐Home Phone ☐Work Phone

May we send you text messages? ☐Yes ☐No May we communicate with you by email? ☐Yes ☐ No May we leave you a voice mail? ☐Yes ☐ No

In accordance with the Medical Privacy Act of Texas, the physicians and/or staff of Greater Houston Digestive Disease Consultants are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release information regarding your care to anyone other than yourself, please complete the following authorization.

I hereby authorize the physicians and/or staff of GHDDC to release information pertaining to my condition and/or care to the individual listed below

May we communicate with anyone on your behalf? ☐Yes ☐ No Contact Name: _____ Relationship _____

_____

Patient or Guarantor Signature

CANCELLATION POLICY

In an effort to best serve our patients; for office visits we will charge a fee of **$25.00** for the cancellation/failure to keep an appointment. The fee charged for the cancellation/failure to keep an appointment of a scheduled procedure will be **$150.00**. Please make every effort to notify this office within 24 hours of your office visit or scheduled procedure if you must cancel or reschedule.

I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

_____ _____ _____

Patient or Guarantor Signature Printed Name Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. By signing below, I acknowledge that I have reviewed or had explained to me the Notice of Privacy Practices and agree to continue my care with Greater Houston Digestive Disease Consultants under said terms.

_____

Patient or Guarantor Signature

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE

It is important to know your insurance plan restrictions regarding the use of a specific labs or x-ray departments. In the event your health plan requires a **Referral** from your primary care physician, and you arrive for your appointment without an authorized Referral, **you will be responsible for the complete charge.** To avoid this charge, you may reschedule your appointment to date after a referral can be obtained.
We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of the service. Please Note: Your insurance carrier requires us to collect your co-payment at each visit.
If your health plan determines that a service is not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
For all services rendered to minor patients, the adult accompanying the patient, the parent with custody or the legal guardian will be responsible for payment.
If you have any questions about the policy, please discuss this matter with our business office staff.
Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service.
Acceptable methods of payments are cash, personal check and for your convenience we accept VISA, and MASTERCARD credit cards.
I **AGREE TO ADHERE TO THE ABOVE INSURANCE TERMS:**

_____ _____

Patient or Guarantor Signature Date

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Today's Date: _____

Patients Name: _____ **Birthdate:**_____ **Age**: _____ **Gender**: F/M

***SOCIAL HISTORY**

Occupation: _____ **Marital Status**: [] Married [] Single [] Divorced [] Widowed [] Partner
Of children _____ Sons _____ Daughters

****Please provide details regarding current and/or past use of the following:**

Alcohol (beer, wine, liquor) ☐No ☐Yes If Yes, how many drinks per day_____
Tobacco (cigarettes, cigars, chewing tobacco, vape) ☐Never ☐Former Stopped_____(Date) ☐Current Every Day
Street Drugs _____

***DRUG ALLERGIES (List All) _____**
_____
_____

***Vitamins, Herbal and Dietary Supplements**:
_____
_____
_____
_____
_____
_____
_____

*** Please list all CURRENT MEDICATIONS:**
Name _____Dosage / # of times daily
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Colonoscopy? Yes / No DATE:_____POLYPS Y/N Previous EGD? Yes / No DATE: _____ Findings?_____

PATIENT MEDICAL HISTORY Check all that apply

- ○ **Cirrhosis**
- ○ **Colon Cancer**
- ○ **Colon Polyps**
- ○ **Crohn's Disease**
- ○ **Diverticulitis**
- ○ End Stage Renal Disease
- ○ **GERD**
- ○ **HEPATITIS B**
- ○ **HEPATITIS C**
- ○ OTHER_____
  _____
- ○ Hiatal hernia
- ○ Irritable Bowel Syndrome
- ○ Liver Disease
- ○ Stomach/ Intestinal Ulcers
- ○ Ulcerative Colitis
- ○ Anemia
- ○ Anxiety/ Depression
- ○ Arthritis/ Osteoarthritis
- ○ Asthma
- ○ Cancer: Type_____
- ○ Cataracts
- ○ Chronic Kidney Disease
- ○ Congestive Heart Disease
- ○ COPD/ Emphysema
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Glaucoma
- ○ HIV/AIDS
- ○ High Cholesterol
- ○ Hypertension
- ○ Hypothyroidism
- ○ Migraines
- ○ Myocardial infarction/ Heart Attack
- ○ Nerve/ Muscle Disease
- ○ Osteoporosis
- ○ Pancreatitis
- ○ Seizures
- ○ Stroke(CVA)

Cardiologist Name_____ Phone Number#_____

***NURSE ONLY ***[] NEW PATIENT [] EST PT/OVER 6 M [] FOLLOW UP [] EXISTING PT FROM SADLER/NEW HERE**

VS:WT:_____BP:_____P:_____HT:_____
CHIEFCOMPLANT:_____

PLAN: [ ] EGD/COLON [ ] COLON [ ] EGD [ ] LABS
[ ] CT_____

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**********FOR OFFICE USE ONLY**********

R10.13 Abd pain, EPIG	R07.9 Chest pain, unspec.	K21.0 Reflux K21.9GERD	R94.5 Abn Liver Labs
R10.11Abd pain, RUQ	K30 Dyspepsia	K21.0 Reflux Esophagitis w/esopagitis	R10.10 Abd pain, Lower
R10.84Abd pain, GEN	R05 Cough	K21.9 Reflux Esophagitis w/o esop	R74.0 Abn Labs
R10.09 Abd pain, UNSP	R13.10 Dysphagia	K92.0 Hematemesis	R93.3 Abn,RAD
R10.12Abd pain, LUQ	K20.9 Esophagitis,UNSP	R11 Nausea/Vomiting	
R10.10 Abd pain, Upper	R11.0 Nausea	K29.40 Gastritis	
R10.33Periumbilical PAIN	K25.9 Gastric Ulcer	K22.710Barretts esoph w/low grade dys	
D50.9 Anemia, iron deficiency	K83.1 Bile Duct Stone Obs	K22.719Barretts esoph w/dysplasia,unsp	
D64.9 Anemia, UNSP	K74.60 Cirrhosis w/out Alcho	K22.711Barretts esoph w/high grade dys	
D50.0 Iron Def, Sec to blood loss	K70.30 Cirrhosis w/o Ascites		
K70.31 Cirrhosis w/Ascites	**B18.2** HEP C		

R10.32Abd pain, LLQ	K92.1 Blood in stool (Melena)	K58.0 IBS w/diarrhea	R63.4 Weight Loss,Abn
R10.31 Abd pain, RLQ	D90.0 Celiac Ds.	K58.9 IBS w/o diarrhea	R63.5 Abn Weight gain
R10.9 Abd. Pain, UNSP	K52.80 Colitis	792.1 Positve stool guaiac	K57.12 Diverticulitis
Z85.030 Pers hx. Colon Ca	K50.90 Crohns,UNSP	R19.8 Change bwl habits	D57.30 Diverticulosis
Z83.71 Family hx POLYPS	K51.80 U/C w/o	K62.89 Rectal pain	K64.8 Hemorrhoids Unspec
Z86.010 Pers hx polyps	K59.00 Constipation	K62.5 Rectal Bleeding	**Z12.11** Colon screening
Z80.0 Fam hx CANCER	K59.01 Slow transit Constipation	R14.3 Gas	

[] CBC 005009/**6399**	[] Ammonia, Serum 007054/**5509**		
[] B12/Folate 000810/**7065**	[] A-1-A (Alpha-1-Antitrypsin) 00198/**17307**		
[] Ferritin 004598/**457**	[] AMA (Anti-Mito-Antibody)006650/**259**	[]	Hepatitis, Acute Panel322744/**10306**
[] Iron and TIBC 001321/**571**	[] ANA (Anti-Nuclear-AB) 164855/**38318**	[]	Hep A AB Total 006726/**508**
[] Retic Count 005280/**793**	[] Actin-Smooth Muscle AB 006643/**15043**	[]	Hep B Surf AB,IgG 006395/**499**
	[] AntiLKMAb 163980/**15038**	[] Hep C Genotype 550475/**37811**	[] Hep B DNA 551432 **/8369 & 34181**
	[] Ceruloplasmin 00156/**326**	[] **HEP BsAg/QUEST 498**	[] Hep Be Ag 00619/**555**
[] IMMUNOGLOBULIN, QUANT 02295 (IgA,IgE,IgE,IgM)/**7083**		[] Hep C RNA Quantitative (Viral Load) 550070/**35645**	
UREA BREATHTEST/QUEST **20325**	[] GGT 001958/**482**	[]	HEP D AB **4990/QUEST**
	[] Hemochromatosis DNA(HFE gene mutation) 511345/**35079**		[]Liver Function Profile 322755 Same as Hepatic/**10256**
[] Haptoglobin 001628/**502**		[]	PT/INR 005199 (protime)/**8847**
[] Hemoglobin Electrophoresis Fractionation 121442/**???QUEST**		[]	PTT 005207/**763**
[] HLA B-27 (disease associations) 006924/**528 & 15584**		[] Lactic Acid Dehydorgenase 001115/**585**	

PANELS	**TUMORS**	**OTHER**
[] BMP(ct for pts over 50) base met 322758/**10165**	[]	[]AFP (Alpha-Fetoprotein 002253/**237** [] ALPHA-FETOPROTEIN (AFP) AND AFP-L/Q19529
[] CMP (base met) 322000/**10231**	[]	[] CA 19-9 002261/**4698** [] CEA 002139/**978** **[] CA 125/QUEST 29256**
[] INTRINSIC BLOCK FACTOR 010413/**568**		[] Antiparietal Cell AB 006486/??
[] (VIP) VASAOCTIVE INTESTINAL POLYPEPTIDE (010397)/**920**		[] Amylase, Lipase 001396/**243 &606**
[] VITAMIN D **Q17306** [] VITAMIN B-12/**927**		[] Calcitonin 004895/**30742**
[] Comprehensive Metabolic Panel (base met) CMP 322758/**10231**	[]	[] CRP 120766 (C-reactive protein)/**4420**
		[] Gastrin Serum 004390/**478**
		[] Hgb-A1C 102525/**496**
		[] H. Pylori Ab (IgG IgM) 162289/**20325**

URINE TESTS: [] HIAA 24 hr Urine 004069/**39625**	[]	[] H.Pylori Breath test 180836 DX: 041.86/**14839**
[]	[] Culture, routine 008847/**395**	[] Intrinsic Block Factor 010413/**568**
[] Sed Rate 005214**/809**	[] UA micro on +'s 003038/**8563**	[] Immunegobulin, Quant 02295 (IgA,IgE,IgG,IgM)/**7083**
[] Trypsin, Serum 010355/**30329**	[]EBV 1gm, 1Gg **Q8426+8474** []HSV 1gm, 1Gg, **??**	[]CMV1gm, 1Gg/**??**
[] Celiac Profile(II) 165142/**19955**	[] Q TB GOLD** **QUEST 19453**	

STOOL TESTS	**THYROID**	
[] C.diff toxin A+B 086207/**37212**	[] HEMOCCULT IN OFFICE X3 182949/**11290**	[] T4 Free T4 total 001149/**36725**
[] Culture Stool 008144/**10108**		[] T3 Uptake T3 total 001156/**861&859**
[] Giardia, direct detect 008623/**8625**	[] CALPROTIEN LEVEL Q/16796	[] TSH 004259/**899**
[] Leukocytes stool 008656/**3930**	[] Cryptosporidium/Isospora Smear	
[] O+P stool 0086323 (ova&parasites)/**681**	[] Cryptoccus Antigen,Serum	

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Surgical History: Check All that Apply and Provide Dates

- ○ Colonoscopy _____
- ○ Hemorrhoid Surgery _____
- ○ Gallbladder Surgery _____
- ○ Gastric Surgery _____
- ○ Liver Surgery _____
- ○ Nissen Fundoplication_____
- ○ Small Intestine Surgery _____
- ○ Appendectomy _____
- ○ Brain Surgery _____
- ○ Breast Surgery _____
- ○ C Section _____
- ○ CABG/ Heart Surgery_____
- ○ Cosmetic Surgery _____
- ○ Defibrillator _____
- ○ Fracture Surgery _____
- ○ Hernia Surgery _____
- ○ Joint Replacement _____
- ○ Laparotomy _____
- ○ Obesity Surgery
  Type If Known _____
- ○ Pacemaker _____
- ○ Prostate Surgery _____
- ○ Spinal Surgery _____
- ○ Thyroidectomy _____
- ○ Tonsillectomy _____
- ○ Transplant Surgery _____
- ○ Tubal Ligation _____
- ○ Valve Replacement_____
- ○ Vasectomy _____
- ○ Other_____
  _____

Family Medical History: Check all that apply: ☐ **Unknown/Adopted**

					Maternal	Maternal	Paternal	Paternal	Maternal		Paternal	
Diagnosis	Mother	Father	Sister	Brother	Grandmother	Grandfather	Grandmother	Grandfather	Aunt	Uncle	Aunt	Uncle
Colon Cancer												
Colon Polyps												
Crohn's/ Colitis												
Liver Disease												
Uterine Cancer												
Kidney Cancer												
Stomach Cancer												
Bladder Cancer												
Pancreatic Cancer												
Ovarian Cancer												
Breast Cancer												
High Cholesterol												
Diabetes												
Stroke												
Heart Disease												

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Systems Review:

Please Indicate items you are **CURRENTLY** experiencing or "**NONE"** If no symptoms exist:

Gastrointestinal ⬭ NONE

- ○ Abdominal Pain
- ○ Anorectal pain/itching
- ○ Black, tarry stools
- ○ Bloating/gas
- ○ Change in bowel habits
- ○ Constipation
- ○ Diarrhea
- ○ Incontinence of Stool
- ○ Heartburn/ Reflux
- ○ Difficulty Swallowing
- ○ Nausea
- ○ Vomiting

Genitourinary ⬭ NONE

- ○ Blood in urine
- ○ Dark urine
- ○ Enlarged prostate
- ○ Frequent urinary infections
- ○ Heavy menstruation
- ○ Pain/burning with urination
- ○ Pregnancy
- ○ Sexually transmitted disease
- ○ Urinary Incontinence
- ○ Frequent Urination

Integumentary/Skin ⬭ NONE

- ○ Itching
- ○ Jaundice
- ○ Rashes
- ○ Suspicious Lesions

Cardiovascular ⬭ NONE

- ○ Heart Murmur
- ○ Irregular heartbeat
- ○ Hand/ankle swelling
- ○ Rapid heat rate/ palpitations
- ○ Chest pain

Neurological ⬭ NONE

- ○ Frequent headaches
- ○ Memory Loss/ confusion
- ○ Numbness or tingling

Endocrine ⬭ NONE

- ○ Cold Intolerance
- ○ Excessive thirst
- ○ Heat Intolerance

Constitutional ⬭ NONE

- ○ Chills
- ○ Fatigue
- ○ Loss of appetite
- ○ Night sweats
- ○ Weight Gain
- ○ Weight Loss

Psychiatric ⬭ NONE

- ○ Anxiety
- ○ Bipolar Disorder
- ○ Depression

Ear/Nose/Mouth/Throat ⬭ NONE

- ○ Double Vison
- ○ Eye Irritation
- ○ Eye Pain
- ○ Eye Redness
- ○ Sore Throat
- ○ Hoarseness
- ○ Mouth Sores
- ○ Nose Bleeds
- ○ Post-nasal drip
- ○ Recurrent sinus infections

Hematologic/Lymphatic ⬭ NONE

- ○ Anemia
- ○ Blood Transfusions
- ○ Easy Bruising
- ○ Prolonged Bleeding

Musculoskeletal ⬭ NONE

- ○ Back Pain
- ○ Join Pain

Respiratory ⬭ NONE

- ○ Frequent cough
- ○ Shortness of breath
- ○ Snoring
- ○ Sleep apnea
- ○ Wheezing

Patient Signature _____ Date_____

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSEU *ERISA* AND OTHER LEGAL AND ADMINSTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE. POVIDERS OF GHDDC.

I hereby assign and convey directly to the above names healthcare provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and /or medications rendered or provided by the above names healthcare provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above names healthcare provider to release all medical information necessary to release to the above names healthcare provider and all plan documents, summary benefits description, insurance policy, and/or settlement information upon written request from the above named healthcare provider or its attorneys in order to claim such medical benefits.

In addition, to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above name healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or lessor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications. I receive from the above-named healthcare provider (including any rights to pursue those legal or administrative claims or choose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intended by this assignment and designation of authorized representative to convey to the above named provider all of my rights to claim (or place a lien on) the medical benefits related to the services treatments, therapies, and/or medications provided by the above named healthcare provider, including rights to any settlement, insurance of applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and /or designated representative for Dr. Awasum or any GHDDC Provider is given the right by me to (1) obtain information regarding the claim to the same extent as me, (2) submit evidence, (3) make statements about facts or law, (4) make any request judicial actions and pursue claims or choose in action or right against any liable party, insurance company employee benefits plan, health care benefits plan, or plan administrator. The above-named provider as my assignee and my designated authorizes representative may bring a suit against any such healthcare benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at providers expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if was the original.

I HAVE READY AND FULLY UNDERSTAND THIS AGREEMENT

_____ _____

Signature of Patient Date

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security#: _____

I request and authorize _____Phone #:_____Fax#:_____
(Name of YOUR PREVIOUS Physician)

To release the medical records of the patient named above to:

Greater Houston Digestive Disease Consultants

Dr. Serge Alain Awasum, M.D.
1120 Medical Plaza Dr. Suite 255
The Woodlands, Texas 77380
Main: 281-205-1111 Fax: 281-419-2111

This request and authorization applies to:
Health Care Information relating to the following treatment, condition or dates of Treatment:

___ **ALL GI RECORDS**
___All health care information
___Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____

Signature of Patient or Patient's Authorized Representative Date Signed

_____ _____

Relationship or status if signed by anyone other than patient Date Signed

(Parent, legal guardian, personal representative, etc)

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with GREATER HOUSTON DIGESTIVE DISEASE CONSULTANTS, Dr. Serge-Alain Awasum may refer you to Memorial Hermann Surgery Center, River Oaks Endoscopy Center, USM Anesthesia, Premier Pathology, VIP Surgical Hospital or Conroe Premier Imaging Center.

In connection with any referral to these Facilities, you are hereby advised that Dr. Serge-Alain Awasum has an investment interest in some of these Facilities and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you both at the time of Dr. Serge-Alain Awasum's first contact with you as a patient and at the time of referral to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician or the Facility if you choose to use a different facility.

By signing below, you certify that you were advised of alternative health care providers/facilities and your right to choose one these alternative health providers/facilities. Further, you confirm and agree that you were assured by your physician that you will not be treated differently by the physician or the physician's staff if you choose an alternative health care provider or entity. Lastly, you further acknowledge by signing below that you signed this Physician Ownership Disclosure Form on the date of your first contact with Dr. Awasum as a patient and at the time of Dr. Awasum's referral of you to the Facility.

Patient name (please print)

_____

Patient signature

_____

Date

_____

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INFORMATION ABOUT YOUR PROCEDURE

Before the procedure

1. Once your procedure is scheduled, a pre-op nurse from the facility will call you a couple of days in advance to review your medications & ask questions about your general health for the anesthesia team. They will tell you exactly where to go on the day of your procedure.

2. The 2 major charges associated with an endoscopy (colonoscopy, EGD) procedure are the doctor's fee & the facility fee. Our office verifies your insurance benefits the day of your initial office visit. If there is a deductible or co-pay to the doctor, a financial counselor will contact you. The facility may also call if there is a fee for their portion. Associated fees for pathology (analyzing biopsy by a doctor) & anesthesia may be separate.

After the procedure

3. Dr. Awasum will come & talk to you & your driver before you leave the facility to tell you what he found during your procedure. You may still be feeling the effects of anesthesia immediately following the procedure, so if there are any instructions, he may give you written instructions.

4. **Dr. Awasum's nurse will contact you with your results**. In most cases, Dr. Awasum will ask you to come back to the office to discuss the results of any tests done, especially if you have had symptoms or questions. Please make a follow up appointment. It is very important, because he can discuss the findings of your test(s) with you & take all of his findings into consideration to determine a plan of action with you.

5. Any specimens removed (polyps) are sent to a pathologist & the results are usually reported to the office by fax within 7 business days. If there is anything appearing worrisome found on your colonoscopy, Dr. Awasum will tell you immediately after your procedure. Those specimens that seem highly suspicious for cancer are sent to the lab ASAP, & generally the results are received within a day.

6. Dr. Awasum's nurse will be contacting you within a week of your procedure to go over your biopsy results. Please keep in mind that the results sometimes take 7 days before they are final. The report & the biopsy results will also be filed in your clinic chart for your primary doctor to review.

I __(PRINT) _____DOB:_____have read & understood this information, along with my preparation instructions the day before my procedure.

_____Date_____

Signature of Patient