UPPER ENDOSCOPY INSTRUCTIONS
900 NORTH MICHIGAN SURGICAL CENTER

APPOINTMENT DATE: __________________ APPORTIMATE START TIME: __________________

Location and Check-In:

The 900 North Michigan Surgical Center is located at 60 East Delaware (Bloomingdale's Building),
15th floor, Chicago, IL 60611, phone number 312.440.5150. Please arrive at least **1 hour** before your
scheduled procedure time to check in. If you are also scheduled to have an **EKG please arrive at least**
**1 hour and 15 minutes** before your scheduled procedure time to check in. Expect to stay at the 900
North Michigan Surgical Center for approximately 2½ hours.

Parking:

The 900 North Michigan Surgical Center offers parking at the Self-Park Garage with **entrance located at 911**
N. Rush Street

You must bring your ticket with you when you check in to be validated by our receptionist in order to receive a
discount. Enter the Delaware Place elevator bank and proceed to the Surgical Center on the 15th floor. The
Delaware Place elevator can be accessed from the southeast side of the parking garage.

Completion of Forms:

Please complete the Health History, Patient Information and Financial Policy forms, as soon as possible.

PLEASE FAX THE COMPLETED FORMS TO OUR OFFICE AT 312.573.9636 or MAIL THE FORMS to
Dr. Perry Kamel’s office at 737 North Michigan Avenue, Suite 620, Chicago, IL 60611-6662.

Upper Endoscopy:

Upper Endoscopy is an examination that enables Dr. Kamel to view the lining of the esophagus, stomach and
duodenum (beginning of the small intestine). A flexible endoscope is used to perform the examination, which
is a thin tube with a tiny video camera at the tip. The endoscope is introduced into the mouth and then gently
advanced down the esophagus, stomach, and then into the duodenum.

Upper Endoscopy is helpful to evaluate upper abdominal pain, nausea and vomiting, heartburn, bleeding
and swallowing problems. Endoscopy is more accurate than X-rays for identifying abnormalities of the
upper intestinal tract. A biopsy--a small piece of tissue--may also be taken to evaluate any observed
abnormality, which is not painful.

Complications with Upper Endoscopy are extremely rare.

Preparing for Upper Endoscopy:

Inform Dr. Kamel if you are on any of the following medications: **anticoagulants (blood thinners), insulin**
or **oral diabetes medications approximately one week prior to your scheduled procedure.** The dosage
of these medications will need to be adjusted or discontinued. Your other medications can be continued. On
the day of your Upper Endoscopy, take all of your routine medications with sips of water. Tylenol or
acetaminophen is perfectly safe to take prior to your Upper Endoscopy.
DO NOT EAT SOLID FOOD FOR 6 HOURS PRIOR TO YOUR PROCEDURE OR AFTER MIDNIGHT IF YOUR UPPER ENDOSCOPY IS SCHEDULED FOR THE EARLY MORNING.

You may have clear liquids up to 4 hours before your Upper Endoscopy: Water, coffee/tea (no added sugar, cream and/or milk is not allowed), soft drinks, clear fruit juices (such as white cranberry juice, white grape juice, apple and lemonade), popsicles, broth or bouillon. Ingestion of Jell-O, sugar, milk and/or cream on the day of the test, may cause your procedures to be delayed or cancelled.

DO NOT TAKE ANYTHING BY MOUTH DURING 4 HOURS PRECEDING YOUR TEST OTHER THAN MEDICINES WITH SIPS OF WATER, INCLUDING SUCKING ON CANDY OR CHEWING GUM.

During the Upper Endoscopy:
Dr. Kamel will explain the procedure and answer all your questions prior to the endoscopy. An anesthesiologist will give you pain and sedative medication through an IV to keep you comfortable during the procedure. Throughout the examination, your blood pressure, heart/respiratory rate, and oxygen level will be monitored. You will be on your left side in a comfortable position as the endoscope is gently passed through your mouth into the upper gastrointestinal tract. The endoscope will not interfere with your breathing, and you may feel a mild pressure in your stomach. The examination usually lasts 15 to 20 minutes, and you will be very comfortable.

After the Upper Endoscopy:
You will be monitored after the procedure in the recovery area for a minimum of ½ hour. Dr. Kamel will discuss your test results with you. Biopsy results take several days to return, and Dr. Kamel will discuss them with you by telephone. You absolutely cannot drive until the following day, and an adult must accompany you home. You may not walk, take a taxi, or any public transportation home unless you are accompanied by a responsible adult.

You may do light activity for the remainder of the day. It is important for you to recognize signs and symptoms that should be reported to your physician, which are: severe abdominal pain, fever (above 100.5°), chills or severe rectal bleeding. Some scant bleeding may occur. Please be aware you will receive written discharge instructions before leaving the Surgical Center.

You can speak to Dr. Kamel if you have any questions or concerns after returning home, either at the office 312.573.2457, or after hours at 312.649.2952.
HEALTH HISTORY FORM

Name: ______________________________  Social Security No: ____________________
Date: ____________________________  Birthdate: ____________________________
Reason for Visit: ____________________________________________________________

**Symptoms:** Please check the symptoms you currently have or had in the past year:

<table>
<thead>
<tr>
<th>General</th>
<th>Fever _____</th>
<th>Chills _____</th>
<th>Weight Gain _____</th>
<th>Weight Loss _____</th>
<th>Fatigue _____</th>
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<tbody>
<tr>
<td>Eyes:</td>
<td>Glaucoma ___</td>
<td>Retinopathy ___</td>
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<tr>
<td>ENT:</td>
<td>Sinus Drainage ____</td>
<td>Hoarseness ____</td>
<td>Sore Throat ____</td>
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<tr>
<td>Heart:</td>
<td>High Blood Pressure ____</td>
<td>Heart Attack ____</td>
<td>Chest Pain ____</td>
<td>High Cholesterol ____</td>
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<tr>
<td>Pulmonary:</td>
<td>Shortness of Breath ____</td>
<td>Cough ____</td>
<td>Asthma ____</td>
<td>Emphysema/Bronchitis ____</td>
<td></td>
</tr>
<tr>
<td>GI:</td>
<td>Abdominal Pain ____</td>
<td>Nausea ____</td>
<td>Vomiting ____</td>
<td>Heart Burn ____</td>
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<td></td>
<td>Difficulty Swallowing ____</td>
<td>Change in Bowel Habits ____</td>
<td>Constipation ____</td>
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<td></td>
<td>Diarrhea ____</td>
<td>Rectal Pain ____</td>
<td>Rectal Bleeding ____</td>
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<tr>
<td>GU: Male</td>
<td>Blood in Urine ____</td>
<td>Urinary Frequency ____</td>
<td>Nocturnal Urination ____</td>
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<td></td>
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<td></td>
<td>Blood in Urine ____</td>
<td>Burning ____</td>
<td>Incontinence ____</td>
<td>Mammogram ____</td>
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<td></td>
<td>Pelvic Exam and PAP Smear ____</td>
<td>Hormone Replacement Therapy ____</td>
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<tr>
<td>Joints/Muscle:</td>
<td>Back Pain ____</td>
<td>Joint Pain ____</td>
<td>Joint Swelling ____</td>
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<td>Skin:</td>
<td>Rashes ____</td>
<td>Cancer ____</td>
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<td>Neurologic:</td>
<td>Stroke ____</td>
<td>Seizures ____</td>
<td>Headache ____</td>
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<td>Psychiatric:</td>
<td>Depression ____</td>
<td>Anxiety ____</td>
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<td>Endocrine:</td>
<td>Diabetes ____</td>
<td>Thyroid ____</td>
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<td>Hematologic:</td>
<td>Anemia ____</td>
<td>Swollen Glands ____</td>
<td>Easy Bruising ____</td>
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**Medical History:** Please list significant current and past medical problems:

1) ____________________  2) ____________________  3) ____________________
4) ____________________  5) ____________________  6) ____________________

**Surgical History:** Please list prior surgeries and date of operation:

1) ____________________  2) ____________________  3) ____________________

**Medications:** Please list medications you are currently taking, dose and frequency:

1) ____________________  2) ____________________  3) ____________________
4) ____________________  5) ____________________  6) ____________________
HEALTH HISTORY FORM  (Cont'd.)

Name: ______________________________  Social Security No: ____________________
Date: ________________                            Birthdate: _____________

Allergies: Please list medications you are allergic to and type of reaction:
  1) ______________________           2) ______________________          3) ______________________

Health Habits: Please check the substances you use and describe how much you use:
   Tobacco _________ Alcohol ___________ Caffeine ___________ Drugs ___________

Social History: Married ____ Divorced ____ Single ____ Widow ____ Partner ____

Children: _________________________   Occupation: ________________________________

Family History: Please fill in your family's health information:

<table>
<thead>
<tr>
<th>Age</th>
<th>Health Conditions</th>
<th>Age at Death</th>
<th>Cause of Death</th>
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</tbody>
</table>

Brothers  ______     _______________________    ______                ___________________

Sisters   ______     _______________________    ______                ___________________

Any significant gastrointestinal illnesses in family members? Please list:

  1) ____________________________________

  2) ____________________________________

I certify that the above information is correct to the best of my knowledge. I will not hold the
doctor, or any members of his staff, responsible for any errors or omissions that I may have in
the completion of this form.

__________________________________________________ _______________________
Signature                                Date

____________________________________ ______________  _______________________
Reviewed By                                Date

-2-
Our office policy requires payment for all medical services at the time of visit, unless other arrangements have been made with the business manager. Date

PATIENT INFORMATION (PLEASE PRINT)

NAME: ___________________________________________ DATE OF BIRTH: ____________________

ADDRESS: ___________________________________________________________ HOME# (         ) ____________

CITY: ___________________________ STATE: ________ ZIP___________ WORK# (         ) __________________

SOCIAL SECURITY #____________________________________SEX:_________ CELL#   (         ) ____________

REFERRED BY: ________________________________________ MARITAL STATUS: S  M  D  W  SEP  PART

PATIENT’S EMPLOYMENT INFORMATION

EMPLOYER: _____________________________________________________ OCCUPATION: _____________________________

ADDRESS: ___________________________________CITY:___________________ STATE: ________ ZIP: __________________

SPOUSE/PARTNER’S INFORMATION

SPOUSE/PARTNER’S NAME: ___________________________ SS# _____________________________________

EMPLOYER: _______________________________________________ WORK# (       ) ____________________________

ADDITIONAL INFORMATION

YOUR PHARMACY: ___________________________________________ PHONE# (       ) _____________________

RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ PARTNER NAME __________________________

INSURANCE INFORMATION

ALL INFORMATION MUST BE COMPLETED OR WE CANNOT SUBMIT YOUR FEE TO YOUR INSURANCE COMPANY

PRIMARY INSURANCE

Policy Holder: ___________________________________________ Relationship to Patient: ________________DOB____

Insurance Co. Name: ______________________________________ Address: _____________________________________

City: ___________ State _____ Zip ___________ ID# ___________ Group# _________

SECONDARY INSURANCE

Policy Holder ___________________________________________ Relationship to Patient: ___________DOB____

Insurance Co. Name: ______________________________________ Address: _____________________________________

City: ___________ State _____ Zip ___________ ID# ___________ Group# _________

I hereby authorize Perry L. Kamel, M.D., S.C. to furnish information to my insurance carriers concerning my treatments and illness, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependants. **I understand that I am responsible for any amount not covered by my insurance(s).**

SIGNATURE___________________________________________________ DATE______________

(Patient and/or guardian, if minor)

Please complete this registration form and fax or mail back with a copy of the front and back of your insurance card as soon as possible. Discounted parking is available at the Self-Park Garage with entrances located at 120 E. Walton Street and 911 N. Rush Street. Please bring your ticket with you to the 900 North Michigan Surgical Center. **The validation provided is good for 3 hours of free parking.** After three hours the validated ticket will provide a $14.00 credit toward parking fees incurred. **You pay at the parking garage, but you need to bring your ticket with you to the office to be stamped.**
FINANCIAL POLICY

Your insurance statement consists of two parts—a patient portion and an insurance portion. When an insurance company is responsible for medical services, you are responsible only for the patient portion. However, when an insurance carrier delays, or withholds payment, both the insurance and the patient portion become your responsibility.

In the absence of insurance carrier payment, our office policy is to bill your credit card for payment in full. We will do our best to work with all insurance carriers.

When your account has gone beyond a 90-day limit, it is extremely important that you speak with your insurance carrier concerning payment. If the insurance carrier eventually pays for medical services, we will refund the charges we have made on your credit card.

Send To: Perry L. Kamel, M.D., S.C.
737 North Michigan Avenue
Suite 620
Chicago, IL 60611

Credit Card Information (please print):

Name of Card Holder: _________________________  ________________________   ____
Last        First                                            MI
Name of Patient: ___________________________     _______________________     ____
Last         First           MI
Name of Card: ____ VISA  ___ MASTERCARD   ___ DISCOVER ___ AMERICAN EXPRESS
Card Number: ____________________________________________________________
Expiration Date: Month (00) ______ 20_____

Authorized Signature: _____________________________________________________

Home Billing Address: ____________________________________________________
Billing Address (if different): _____________________________________________
Home Phone: ___________________________       Work Phone: _____________________
Cell Phone: _________________________________
PERRY L. KAMEL, M.D., S.C., FINANCIAL POLICY

ILLINOIS STATE LAW requires insurance carriers to pay claims within 30 days of receipt. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. Many, in fact most, insurance carriers have been very slow in reimbursing physicians for medical services and are therefore not in compliance with these regulations.

Perry L. Kamel, M.D., S.C., has instituted a policy addressing unpaid charges which have been submitted to your carrier. If your account is three (3) months or more past due, it may become your responsibility to pay the remaining portion, which will appear on your patient account statement. We will contact you prior to making a charge to your personal credit card for outstanding balances beyond three months.

If your insurance company forwards payment after you have paid your balance, we will gladly credit your account.

We suggest that you monitor your personal account with us very closely and follow the balance as it ages beyond thirty days, at which time you should call your insurance company and request a "claim status report".

Keep in mind the following points when speaking with the insurance claim manager:

- Identify the date of service for the unpaid claim
- Record and retain the date that you called the insurance company
- Record and retain the name of contact with the insurance company
- Identify and correct the problem causing payment delay
- Verify that the insurance company has the appropriate billing information including:
  - Full name of insured
  - Full address of insured
  - Guarantors name of policy
  - Social security number for the guarantor
  - Correct billing address for your policy
  - Insurance policy number

Ask the claims manager when you can reasonably expect a reimbursement and correction of the problem.

Follow up periodically with the same person to ensure activity occurs on your personal account.

Please complete the credit card information sheet in order to ensure proper continuity of care within our practice. When your insurance carrier is holding or denying payment for medical services rendered, it is best if you call them directly with your concerns and questions.