Western Washington
Medical Group
Gastroenterology

Dear Patient,

Thank you for choosing Western Washington Medical Group Gastroenterology Physicians to provide your medical care.

Enclosed you will find information that will help you prepare for your upcoming procedure at our Endoscopy Center.

Once forms are complete, please bring with you to your appointment.

This information includes:

Patient Registration Form
Friends and Family Form
Medication List

Patient information only:

Informed Consent for Gastrointestinal Endoscopy Paceline
Consent for Anesthesia & Financial Responsibility
Self-Referral Act
Patient Rights and Responsibilities
Financial Agreement
Late Cancellation/No Show Policies; GI Office/Endoscopy
Frequently Asked Colonoscopy Preparation Questions
Endoscopy Center Map

The Endoscopy Center **requires that you have a driver who will remain on the premises during your entire stay**. Plan for you and your driver to spend 2 hours at the Endoscopy Center.

The reception staff will verify that your escort/driver has accompanied you at the time of your check in. **If your escort/driver does not check in with you or chooses to not remain at the Endoscopy Center, your procedure will be cancelled, rescheduled and a late cancellation fee charged**. The Center does not have the facilities or the staffing available to keep a patient, who has received sedation, for many hours after their procedure.

The following steps are very important; if not followed, it could result in your insurance not covering your exam, or cancellation of your exam.

- If your insurance plan requires a referral and one has not been obtained, please contact your Primary Care physician's office and ask them to send a referral to our office as soon as possible. This referral must cover both the physician who is performing the exam, as well as Western Washington Medical Group Endoscopy Center, which is the facility where we typically perform these exams. The physician's name will be provided to you at the time your appointment is scheduled.

- Call your insurance company and ask if your plan will cover a **screening examination**. This is a very important step. You should also know that if pathology (i.e. polyps or inflammation) is found on the exam, the procedure may not be billed as a screening exam. Additionally, your insurance company may not consider this as a screening procedure and may not cover at 100%. Here are the procedure codes that your plan may need:

    - Colonoscopy CPT code 45378-45385
    - Upper GI Endoscopy CPT code 45235-43239

- We request a copy of the front/back of your insurance card at least two weeks prior to your scheduled appointment. Many plans require **pre-authorizations** for these procedures, which may take several days to review. This is true even if your insurance does not require a referral.

If you have any questions or concerns regarding any of this information, please call our office at (425) 259-3122; select the appropriate option.

Sincerely,

The Physicians and Staff of Western Washington Medical Group Gastroenterology and Endoscopy Departments

WESTERN WASHINGTON MEDICAL GROUP **REGISTRATION FORM**

DEPARTMENT OF GASTROENTEROLOGY & ENDOSCOPY

ACCOUNT#________________ NEW _____ UPDATE ______

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE ETHNICITY	SOCIAL SECURITY # PREFERRED LANGUAGE

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT
STREET ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

HOME PHONE	WORK PHONE EXT	CELL PHONE
( )	( )	( )

REFERRING DOCTOR	MARITAL STATUS MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE DOCTOR	SINGLE _____ WIDOWED _____ SEPARATED _____
PHARMACY NAME, PHONE NUMBER AND LOCATION	PREFERRED EMAIL ADDRESS

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED_________ OR DISABLED________)

EMPLOYER NAME	OCCUPATION

STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER	

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___	SUBSCRIBER'S ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER	

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___	SUBSCRIBER'S ID #	GROUP NUMBER

EMERGENCY CONTACT (NOT LIVING WITH YOU)	NAME	RELATIONSHIP	PHONE NUMBER- HOME/WORK/CELL ( )

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ SELF (* If self do not fill in right field.)	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI
_____ SPOUSE _____ PARENT	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT
_____ GUARDIAN	HOME PHONE ( )	WORK OR CELL PHONE EXT ( )	DATE OF BIRTH	SEX M F

WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ____________________________________ ***DATE***

For office use only

Dr.______________________ **Ins. code**_________________________ **Acct #** ____________________________ **Initials** ______

Western Washington
Medical Group
Gastroenterology

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information.

I will rely on the professional judgement of my provider and their designee to share such information, as they deem necessary and appropriate. I understand that information is limited to verbal discussions and that no paper copies of my **Personal Healthcare Information (PHI) will be provided without my signature** to release information from my medical record. I, the patient, may be asked to sign a Release of Information (ROI) to allow WWMG to share information if my provider and their designee deem it necessary.

This consent will be considered valid until such time that I, the patient, revoke it. I reserve the right to revoke this at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: ___________________________ Relationship: __________________ Phone: ______________________

Name: ___________________________ Relationship: __________________ Phone: ______________________

Name: ___________________________ Relationship: __________________ Phone: ______________________

Patient's Personal Phone Information

Note: This is different from the above information.

Please provide YOUR most current phone contact information. This information will become part of your permanent medical record until you change it. You can change this information by completing a new form at any time.

Please note: By choosing the option to leave a detailed message, you are allowing us to leave sensitive health information and specific details related to referrals.

First phone number: ____________________________ Cell Home Work OK to leave detailed message: YES NO

Second phone number: __________________________ Cell Home Work OK to leave detailed message: YES NO

Third phone number: ___________________________ Cell Home Work OK to leave detailed message: YES NO

_______________________________________ _______________________________________
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

_______________________________________ _______________________________________
PRINTED NAME DATE

DATE:

PATIENT NAME:

DATE OF BIRTH:

PHARMACY NAME

PHARMACY PHONE #

LOCATION

PHARMACY FAX #

Please list all medications including **over the counter medications, vitamins, antacids and herbal preparations that you are currently taking.

Aspirin ☐ **Ibuprofen/Advil/Aleve** ☐ **Arthritis medication** ☐

DATE STARTED	NAME OF MEDICATION, DOSE	# of times per day	PRESCRIBED BY
	EXAMPLE		
9/10/2009	NEXIUM 40 MG	1 x per day	Dr. XYZ

Western Washington Medical Group
Endoscopy Center

PATIENT COPY ONLY

(You will receive a copy of this consent form at the Endoscopy Center on the day of your procedure, you will be asked to sign it in front of a witness at that time.)

Justin Cuschieri, MD   Edward Slosberg, MD   James Mu, MD   Sujoy Ghorai, MD   Maiyen Hawkins, DO   Eduardo Chua, MD

INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Operation/Procedure: ☐Colonoscopy/Sigmoidoscopy with possible biopsy and/or polypectomy

☐Upper GI Endoscopy with possible biopsy/polypectomy/dilation ☐Upper GI Endoscopy with Bravo pH capsule

☐Upper GI Endoscopy with Pill Cam Placement

*Endoscopy photography may be done at selected intervals during the procedure.

I consent to the administration of intravenous sedatives and possible anesthesia or other medications before, during and after the procedure by the physician listed above or other qualified medical personnel. I understand that all sedatives/anesthetics involve the rare potential of risks and complications such as damage to vital organs including the brain, heart, lungs, liver, spleen and kidneys; paralysis, cardiac arrest, and/or death from both known and unknown causes. I understand that these medications involve the potential of risk to a fetus in the event of pregnancy, of most concern in the first trimester, resulting in miscarriage or deformity. I understand that on rare occasion IV sedatives may cause phlebitis at the IV site.

I understand that there are potential risks and complications with any medical or surgical procedure. I acknowledge that no guarantee has been made to me about the results of this procedure. Although it is impossible to list every potential risk and complication, I have been informed of some of the possible risks and complications of this procedure which may include but are not limited to the following: perforation of the colon (large intestine) or esophagus, perforation of esophagus with dilation, perforation of the colon with sigmoidoscopy, bleeding of the colon if large polyps are removed, splenic injury, adverse reactions to medications, aspiration of stomach contents and the possibility of missed lesions. I understand there is a slight and unknown risk to the fetus if I am pregnant. Complications associated with the Bravo system include premature detachment of the capsule, failure of the capsule to slough off in a timely period or discomfort associated with the capsule requiring endoscopic removal. Risks involved with Pill Cam capsule endoscopy include retention of the capsule requiring surgical retrieval and injury to the intestinal tract if undergoing MRI scan prior to passage of the capsule.

These potential risks and complications could result in the need to repeat the procedure, additional medical or surgical treatment or procedures, hospitalization, blood transfusions, or very rarely permanent disability or death. I recognize that during the course of treatment conditions may require additional treatment or procedures and I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures as is required. The alternatives to endoscopic procedures are typically barium studies, such as upper GI series or barium enema.

COPY ONLY – DO NOT SIGN THIS DOCUMENT

Anesthesia & Financial Responsibility Consent

I authorize the certified registered nurse anesthetists (CRNAs) of Paceline Anesthesia PLLC to perform Monitored Anesthesia Care (MAC), and/or Total Intravenous Anesthesia (TIVA) as may be deemed advisable as a part of my upcoming Procedure.

All types of anesthesia involve some risk. These risks include, but are not limited to, allergic or adverse drug reactions, respiratory depression, hypoxia (low blood oxygen), low blood pressure, nausea, vomiting, arrhythmias (disorders of regular rhythmic beating of the heart), and injuries to the vein. Complications from anesthesia are uncommon, but may occur. There is a remote possibility of death as a complication of anesthesia. No guarantee has been made that sedation will eliminate awareness, anxiety, or discomfort.

I acknowledge that these risks have been discussed with me and that I have been given the opportunity to have all my questions answered.

Pregnancy and Moderate to Deep IV Sedation Medication: I understand that there are risks involved with IV sedation and to my knowledge, I am not pregnant. If there is a question that I may be pregnant, then I will allow a urine pregnancy test prior to my procedure or sign a separate waiver accepting these risks.

I understand that if I have not prepaid the anesthesia fee that I will receive a bill from Paceline Anesthesia PLLC for its anesthesia services. As a courtesy to me, and as is customary in the medical field, I may receive a bill from Paceline Anesthesia PLLC, who is acting solely as an agent in collecting and remitting amounts owed to Western Washington Medical Group for services provided by Paceline Anesthesia PLLC. I understand that I am ultimately liable to Western Washington Medical Group for its fees.

Insurance claims will be submitted on my behalf to the insurance company specified during the registration process. I certify that I have provided the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.

If I have financial difficulty or have any questions, I will contact the Paceline Anesthesia Billing Office to discuss my account. Non-payment of accounts will result in referral to an outside collection agency that could impact my credit record. Legal fees and collection costs incurred to collect outstanding accounts will be my responsibility.

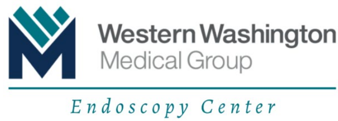
I have read all of this form and understand and agree to the terms set forth in this Acknowledgement of Anesthesia and Financial Responsibility and that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the with Paceline Anesthesia PLLC.

“PATIENT SELF REFERRAL ACT OF 1995”

Beginning January 1, 1995, any physician investor and the entity to which the physician refers a patient must make certain disclosures to the patient.

By this statement, let it be known those physicians, Friedrich C. Loura, M.D., Edward A. Slosberg, M.D., James Z. Mu, M.D., Sujoy Ghorai, M.D., Maiyen Hawkins, D.O., Justin Cuschieri, MD., and Eduardo Chua, MD are currently physician investors in ***The Endoscopy Center – Western Washington Medical Group***, an ambulatory surgery center. These physicians have chosen the Endoscopy Center for a variety of reasons. The most significant reason is that the facility was designed and built specifically for gastrointestinal endoscopy to meet the special needs of our patients. Secondly, the staff of the Endoscopy Center consists of gastroenterology nurses who have been specifically trained to assist in all endoscopic procedures. The physicians thereby have the advantage of working with the highest quality of gastrointestinal nurses in the Puget Sound area. This will contribute to the highest level of quality care.

Another reason for the physicians’ participation was to take an active part in controlling the ever increasing medical costs associated with endoscopic procedures. Procedures performed at other ambulatory surgery centers and local hospitals are considerably higher than the cost of procedures performed at the Endoscopy Center of Western Washington Medical Group. A list of alternate facilities where endoscopic procedures can be performed is available upon request at the reception desk.



PATIENT RIGHTS AND RESPONSIBILITIES

The medical staff of The Endoscopy Center has adopted the following list of patient rights and responsibilities. This list shall include, but is not limited to:

THE RIGHT TO:

- Exercise your rights without fear of discrimination, reprisal, abuse or harassment.
- Be treated with respect, consideration and dignity and without abuse or neglect.
- Be provided access to appropriate protective services/agencies and interpretation services.
- Security, spiritual care, and communication. If communication restrictions are necessary for patient care and safety, it will be documented and explained.
- Know the name and professional status of those caring for you.
- Clear and complete information concerning your condition and care, significant risks involved, reasonable medical alternatives, and a prediction of the effect on you. When it is medically inadvisable to give such information, the information is provided to a person designated by you or to a legally authorized person.
- Be informed of any unanticipated outcomes.
- Personal privacy and confidentiality of information, and, except when required by law, the opportunity to approve or refuse the release of disclosures of medical information.
- Seek another medical opinion or change physicians as well as refuse treatment or leave the center, even if this is against medical advice.
- Receive a copy of your bill and an explanation of the charges, regardless of source of payment.
- Be informed that Advance Directives **cannot** be honored in this facility and to be advised that should an unexpected life threatening event occur, you will be transferred to a facility that will honor your directive. Please have a copy with you if available. Advance Directives information can be found at http://www.wwmedgroup.com
- Have a person who is appointed under state law to act on your behalf regarding patient rights if adjudged incompetent under applicable state laws by a court of proper jurisdiction.
- Designate any legal representative or surrogate in accordance with state law to exercise your patient rights to the extent allowed by state law if a state court has not adjudged you incompetent.
- Express any comments, concerns or grievances regarding the care given to you without fear, retribution or denial of care, and expect resolution in 10 days or less.

THE RESPONSIBILITY TO:

- Actively participate in decisions involving your care and treatment including resolving problems with care decisions.
- Be as accurate and complete as possible when providing information about your medical history, allergies, sensitivities and **all** medications (including supplements and OTC medications) you are taking.
- Cooperate fully on mutually accepted courses of treatment or notify your physician if you do not wish to follow his or her advice or instructions.
- Inform your physician or nurse if you do not understand the plan of treatment and what is expected of you. Adhere to the center's driver policy in that your driver must remain at The Endoscopy Center for the duration of your care.
- Notify your physician or nurse if you notice any changes in your health.
- Act in a considerate and cooperative manner and respect the rights and property of others. Concealed weapons, abusive, threatening or inappropriate language or behavior will not be allowed or tolerated.
- Accept personal financial responsibility in payment of your bill.

Our goal is to provide the best experience possible while in The Endoscopy Center. **Please fill out our patient satisfaction questionnaire prior to your discharge.** Patients, clients, families or visitors have the right to express complaints or concerns about any aspect of their care or experience. Concerns may be directed to any staff member or the Endoscopy Center Nurse Manager or comments can be mailed to:

The Endoscopy Center
Nurse Manager
12800 Bothell-Everett Hwy Suite 200
Everett, WA 98208

Should you feel your concerns are warranted you may contact: **Office of the Medicare Ombudsman** www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html or mail your complaints to:

HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98045-7857

Phone: 360-236-4700
Toll Free: 800-633-6828
Fax: 360-236-2626 E-mail: HSQAComplaintIntake@doh.wa.gov

Western Washington Medical Group

Gastroenterology

READ ONLY

FINANCIAL AGREEMENT

We consider all patients as **"private"** unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "**private**" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient's responsibility to check their benefits prior to being seen. Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service. If you are unable to pay your co-pay at time of service, there will be an **additional $15.00 fee** charged to your account.

A late cancellation or "no show" is someone who misses a procedure appointment without cancelling **5 business days in advance** or someone who fails to present at time of a scheduled procedure. The patient will be charged $250.00 for either late cancellation or no show.for procedures of $**250.00** will be charged if not cancelled a minimum of 72 hours prior to the procedure.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of service, collection fees, reasonable attorney fees and court costs.

We charge **$35.00** for any NSF checks (per RCW 62A-3-515 & 520).

I understand if I have received anesthesia, I will receive a separate bill from Paceline Anesthesia PLLC for its anesthesia services.

I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.

Western Washington Medical Group
Gastroenterology

READ ONLY

WWMG-GASTROENTEROLOGY
Office Appointment Late Cancellation and No Show Policies

Late cancellations or no-shows cause unnecessary longer wait time for patients who need to be seen in the office. In order to provide quality medical care in a timely manner, we have to implement a no show/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

To cancel and/or reschedule an office appointment, patients must call 425-259-3122 during business hours (Monday through Friday 8:30am to 5:00pm, closed 12:00pm to 1:00pm for lunch).

Advanced cancellations: If an office appointment is cancelled or rescheduled **48 hours before** the scheduled time, it is considered an advanced cancellation and there will be no cancellation or reschedule fee.

Late cancellations: If an office appointment is cancelled or rescheduled **within 48 hours** of the scheduled time, it is considered a late cancellation. The patient will be charged a late cancellation fee of $100.00.

No Show: If patient fails to present at the time of a scheduled appointment without prior notice, it is considered a "no show." The patient will be charged a "no show" fee of $100.00.

Insurance companies will not be billed for this fee, which is the sole responsibility of the patient. However, the patient will not be charged if there was a medical emergency and the patient was in the ER or hospitalized at the time of scheduled appointment.

Payment schedule: From the date of the no show or late cancellation, the patient has 60 days to make the payment for the no-show or late cancellation fee.

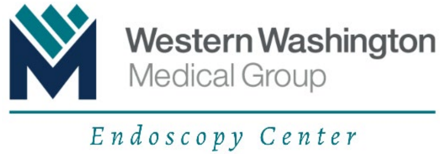
- During the 60 days before payment is made by the patient, the patient must make a $100.00 deposit to reschedule a non-emergent office appointment. The deposit will not be refunded if the patient has another late cancellation or no show. We will continue to provide emergency gastroenterology care and prescription renewals for 60 days without a deposit.

- At the end of the 60 days, if the payment is still not received, a Termination of Care letter will be sent to the patient, notifying the patient of discharge from the practice. Emergency gastroenterology care will be provided for an additional 30 days from the date of Termination of Care letter.

- The patient may be admitted back to the practice if the fee is paid after the 60 day "grace period". However, the patient must make a $100.00 deposit for the first office appointment (this requirement is only for those who did not pay fees within 60 days and were discharged). If the patient cannot afford or is unwilling to make the deposit, the patient cannot be admitted back to the practice.

Each patient will be tracked for the number of no shows and late cancellations. If the number of either or the combination of late cancellations and no shows exceed three (3) occurrences within any consecutive 12 months, the patient will be discharged from the practice and no further appointments will be scheduled.

Revised 08/01/2024



READ ONLY

WWMG-GASTROENTEROLOGY

Endoscopy Procedure Late Cancellation and No Show Policies

A late cancellation or "no show" is someone who misses a procedure appointment without cancelling **5 business days in advance** or someone who fails to present at the time of a scheduled procedure without notice. ***The patient will be charged $250.00 for either late cancellations or no shows. The procedure cannot be re-scheduled until the $250.00 charge is paid by the patient.*** Insurance companies will not be billed for this fee.

This agreement applies to endoscopy procedures performed by our providers at WWMG Endoscopy Center, Providence Medical Center, and/or Island Hospital.

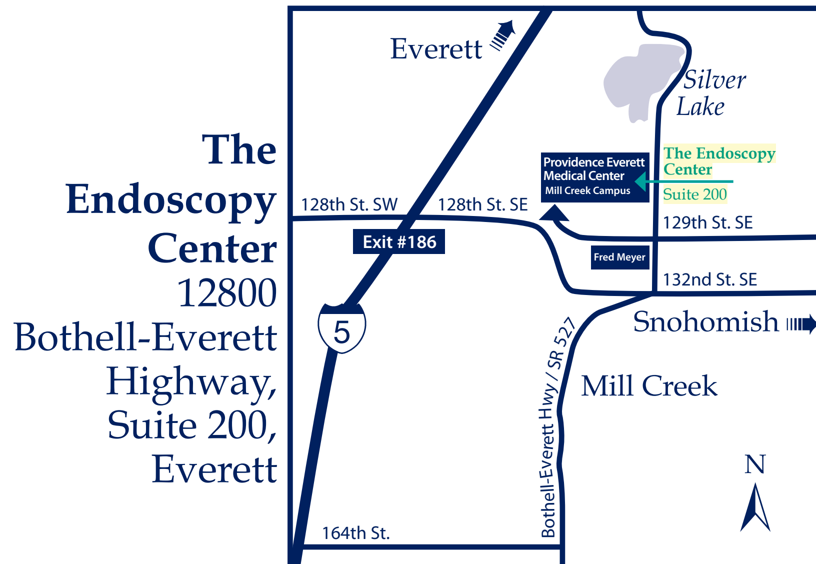
Western Washington
Medical Group
Gastroenterology

FREQUENTLY ASKED COLONOSCOPY PREPARATION QUESTIONS

Please read your 5 Day preparation planner immediately upon receiving

1. **When is the last time I can have clear liquids to drink?**
   - You may have clear liquids up to 4 hours prior to your check-in time. Please avoid all liquids that are **RED**, **BLUE**, or **PURPLE** in actual color.
2. **Can I start my prep earlier/later?**
   - Yes, but no earlier than 1 hour before start time and no later than 1 hour after start time.
3. **If I start to vomit, what should I do?**
   - If you vomit only a few times, take a break, lengthen time between glasses until this resolves. If vomiting is continual and excessive, call the on-call physician at (425) 259-3122.
4. **I drank almost all of my prep and still have not gone to the bathroom. What should I do?**
   - During business hours, 8am-5pm, call GI Prep Line (425) 259-3122. If it is after hours, call the GI office for the on-call physician at (425) 259-3122.
5. **What happens if my prep is not adequate?**
   - It is very important that you are clean which should occur if you follow the exact 5 day prep planner. This will improve the chance of visualizing colon polyps or abnormalities during your exam. If your prep is not adequate, your procedure may be canceled and rescheduled or your procedure time will be delayed in order to allow time to drink more prep solution. If the procedure is attempted but aborted due to a poor prep, you may be asked to return for a second procedure, using more bowel prep and you will be charged for the second procedure.
6. **My family member did a different prep. Can I do the one that they did instead?**
   - No, your prep regimen has been prescribed specifically for you by the doctor.
7. **The pharmacist gave me a different bowel prep, and/or the instructions on the container are different from the instructions on my prep planner. What should I do?**
   - Call the office (425) 259-3122 immediately to receive instructions that coincide with your prescribed bowel prep.
8. **What if I do not have a driver or they cannot stay for the entire time?**
   - Your procedure will be canceled if your driver is not in the building at all times. **This is a strict policy.** You have the option of rescheduling your exam. In certain circumstances the procedure can be done without sedation, though if unsuccessful, you may be asked to return for a second procedure, with a driver and you will be charged for the second procedure.
9. **Will I be knocked out?**
   - You will receive anesthesia/Propofol. This is guaranteed sleep through entire procedure and has quicker recovery, usually no nausea and no memory loss.
10. **What if I am on my monthly menses?**
    - This will not affect your procedure in any way (tampon or pad okay).
11. **Should I bring my CPAP machine?**
    - No, you will not need it during the procedure.

Revised 04/18/2025



Directions

From I-5 traveling north, take the 128th Street SW exit, (Exit #186). Go right onto 128th Street SE and drive east.

From I-5 traveling south, take the 128th Street SW exit, (Exit #186). At the stoplight go left onto 128th Street SE and drive east.

Follow 128th Street SE past McCollum County Park. 128th St. SE will turn into 132nd St. SE. Turn left on 19th Ave. SE (SR 527) – Fred Meyer will be on the left side of the intersection – and head north for one block.

Turn left at 129th Place SE (stoplight) and go straight ahead. The road will curve to the right, behind Fred Meyer, and lead you directly into the parking lot of Providence Everett Medical Center – Mill Creek campus.

The Endoscopy Center is located in Suite 200, on the 2nd floor, at the top of the stairs.