MIDDLESEX DIGESTIVE HEALTH & ENDOSCOPY CENTER

45B Discovery Way, Acton MA01720
Phone: 978-429-2010 • Fax: 978-264-1936

45A Discovery Way, Acton MA01720
Phone: 978-429-2000 • Fax: 978-264-1935

COLONOSCOPY PREPARATION (Sutab)

*****PLEASE READ ENTIRE PACKET AT LEAST ONE WEEK PRIOR TO YOUR APPOINTMENT*****

Dear Patient,

If you are a new patient, you have received this paperwork in order to set up a procedure.
If you are an existing patient and have received this packet, you are due for a follow-up procedure.

******Please look for an email or text with a link to input your personal and health information starting approx. May 7th 2024- Please fill out at least 5 days prior to your procedure.******

If your procedure is before that date or you prefer to fill out the attached forms, please complete and attach a copy of your ID and insurance card (front and back) and return these to the center as soon as possible.

PLEASE ALSO BRING YOUR INSURANCE CARD AND A VALID ID WITH YOU ON THE DAY OF YOUR PROCEDURE.

If your insurance requires a referral, please contact your primary care physician to obtain one. You may have a deductible, coinsurance, or copay for your procedure. Please contact your insurance company to review the coverage and costs of your procedure so you are aware of any potential additional expenses. Final determination of patient responsibility is determined when the claim is processed. For procedures, there is a facility fee, professional fee, a possible pathology fee which would be from Gastro Health, Greater Boston GI/Atrius Health, and an anesthesia fee from Greater Boston Anesthesia.

Please call if you have the following conditions (these may require additional instructions for safety):

- **Take an Anticoagulant** (Coumadin/Warfarin/Eliquis/Xarelto/Brillenta), Plavix or Aspirin 325mg
- Had any **recent cardiology concerns and/or cardiac surgery**, cardiac stent placement within the last 12 months or have ever had a cardiac valve replacement and require antibiotics prior to medical procedures
- Have **medication-dependent diabetes** or take a **GLP1 or SGLT2i medication for weight loss or diabetes** (Ozempic, Trulicity, Wegovy, Jardiance, Invokana etc.) call at least 7 days prior to procedure to avoid possible cancellation.
- Have a history of long QT syndrome, allergy to Zofran (ondansetron), or if you are taking Apokyn (contraindicated with Zofran)
- Have had a recent cold, cough, congestion or diagnosed with Covid-19 within the last 10 days.

Cancellation Policy: A 48-hour advanced notice is needed for cancellations. If you neglect to give 48-hour notice, a ***$150 fee*** will be charged to cover administrative costs. After 2 missed appointments, you will not be rescheduled.

Please arrange a ride home. Due to the effects of anesthesia, you cannot drive yourself home and cannot take a taxi, Uber/Lyft, etc. unless accompanied by a responsible adult. Your ride should be available at all times. The facility closes by 3:30pm so please ensure your ride can accommodate this.

Location: Middlesex Endoscopy Center, 45A Discovery Way Acton, MA 01720 Phone: 978-429-2000
If your procedure is booked at Emerson Hospital, please pre-register there at 978-287-3062.

What To Expect For Your Colonoscopy Procedure

BEFORE YOUR PROCEDURE

Obtaining Colonoscopy Prep: EZ2go prep kit is available for pick up at Middlesex Endoscopy Center 45A Discovery Way Acton, MA 01720

Preparation: Time-sensitive instructions included regarding prepping for colonoscopy. (Must read at least 5 days prior)

Pre-procedure Questionnaire: We are in the process of implementing an electronic intake system. You may receive an email or text asking you to submit your personal information, health history and medications. If you complete this electronically you do not need to fill out the pre-procedure medical form in this packet.

AT YOUR PROCEDURE (Average Total Time at Center 1.5-2.5 Hours)

Check-In: Please arrive 30 min before your procedure time. We will verify personal and insurance information (please bring license and insurance card). We will have you sign facility consents and provide name/number for your ride home.

Pre-Procedure: A nurse will review medical history, current medications, record vital signs and have you change. (A shirt with a sleeve that can roll up above the elbow can remain on.) An intravenous (IV) catheter will be placed for hydration, anesthesia and other medications as needed. You will discuss the procedure risks/benefits and sign consents for the anesthesiologist and the gastroenterologist.

Complications from this procedure are rare. There are slight risks such as bleeding, tearing a small hole in the intestine, or inflammation of the vein used for the IV medication. Your doctor will explain these and other risks in full and answer any questions you may have before consents are signed.

Procedure: In the procedure room, monitors and oxygen will be set up. The anesthesia provider will administer the medication through the IV once the team is ready to begin. The medication most commonly used is called propofol and causes a light sleep. You are unaware of the procedure but breathing on your own.

During a colonoscopy, a scope is introduced into the rectum and moved throughout the large intestine (colon). Your doctor will examine your colon looking for anything of concern, take biopsies, and/or remove polyps as needed. Please note that most polyps found are not cancerous. The adverage procedure time is 20 minutes.

Recovery: Your ride will be notified to arrive. Vital signs will be monitored as you wake up in the recovery area. The procedure may cause cramping/bloating so gas may need to be passed during this time. Once stable, your IV will be removed and then you can get dressed. You will be offered water to drink. You will receive verbal and written discharge instructions and your doctor will review your exam with you before you leave. No driving, drinking alcohol, or recreational drug use on the day of your procedure for safety and anesthesia purposes. Average recovery time is 30 minutes. **Please arrange a ride home**. **Due to the effects of anesthesia, you cannot drive yourself home and cannot take a taxi, uber/lyft, etc. unless accompanied by a responsible adult. Your ride should be readily available at all times. Facility closes by 3:30pm.**

Valuables are not the responsibility of the Center
Patients are encouraged to leave all valuables at home to avoid the possibility of loss or theft. Valuables including jewelry, money, cell phones, computers, dentures, hearing aids, etc.

Please visit our website www.middlesexdigestive.com for more information, as well as directions our facility.

<u>SUTAB</u> Bowel Preparation for Colonoscopy

All 24 tablets are needed for a successful preparation
(follow these split-dose 2-day instructions not the box instructions)

SUTAB is a prescription item that is called into your preferred pharmacy. If you have not picked up your prep 5 days prior to your procedure, and your pharmacy does not have a prescription called in, notify Gastro Health @ 978-429-2010. If prone to constipation or difficulty having regular bowel movements please purchase over the counter Ducolax laxative tablets.

<u>5 Days Prior to Procedure:</u> start eating a **low fiber diet** (see low fiber diet page)

Stop multivitamins, iron, vitamin E, calcium, NSAIDs (advil, ibuprofen, motrin, aleve, etc.) and aspirin. Baby Aspirin 81mg and Tylenol are ok to continue. If you take an **Anticoagulant, Plavix, Aspirin 325mg, a GLP1 antagonist (ex. Ozempic, Trulicity, Wegovy, etc.)** or an **SGLT2i medication (ex. Jardiance, Invokana etc.)** please call our office 978 429 2010 for further instructions to avoid a possible cancellation.

<u>Day Before Procedure</u> -Start **clear liquid only diet** – See clear liquid diet page
8 AM: If you are prone to constipation, take (3) over-the-counter Dulcolax laxative tablets.
4 PM: Take 4mg of Zofran to prevent nausea from the prep (Do not take if you have a history of long QT syndrome, allergy to Zofran, or if you are taking Apokyn)
5 PM: Open 1 bottle of 12 tablets**.** Fill the empty container with 16 ounces of water (to the fill line). Swallow 1 tablet with a sip of water, wait 1-2 minutes and proceed to take another tablet with a sip of water. Follow the same steps until the 12 tablets and 16 ounces of water are finished. (If you feel uncomfortable, take tablets and water at a slower rate)
1 hour after finishing tablets: Fill the empty container with 16 ounces of water (to the fill line) and drink the entire amount over 30 minutes. Then approximately 30 minutes after finishing the previous container of water drink another 16 ounces of water over 30 minutes.

Important to Note: Chills, nausea, and abdominal cramping are normal responses to the prep.
Call 978 429 2010 if you are unable to tolerate the prep

<u>Day of Procedure</u>- **Clear liquid diet** (up until 4 hours prior to procedure) + **Bottle 2 of Prep** see below.
6.5 hours prior to procedure time: Take 4mg of Zofran to prevent nausea from the prep.
6 hours prior to procedure time: Open 2nd bottle of 12 tablets**.** Fill the empty container with 16 ounces of water (to the fill line). Swallow 1 tablet with a sip of water, wait 1-2 minutes and proceed to take another tablet with a sip of water. Follow the same steps until the 12 tablets and 16 ounces of water are finished. (If you feel uncomfortable, take tablets and water at a slower rate)
1 hour after finishing tablets: Fill the empty container with 16 ounces of water (to the fill line) and drink the entire amount over 30 minutes. Then approximately 30 minutes after finishing the previous container of water drink another 16 ounces of water over 30 minutes.
4 hours prior to procedure time: Nothing to drink (even water or ice chips) or procedure will be delayed.

If you are not having clear yellow bowel movements after 2nd bottle of SUTAB, call us at 978-429-2010.

Please keep in mind that is an estimated appointment time, because the time involved in each procedure is often unpredictable, and procedures are scheduled to follow each other consecutively. There are occasions when the schedule runs behind. Your patience and understanding are appreciated.

LOW FIBER DIET

A low fiber diet is easy to digest and does not leave residue in the colon before procedure.

Type of Food/Drink	YES – OK To Have	NO – Avoid These
Milk and Dairy	Milk, Cream, Hot chocolate, Buttermilk, Cheese including cottage cheese, Yogurt, Sour cream	No yogurt that has nuts, seeds, granola, fruit with skin or berries
Bread and Grains	Breads and grains made with refined white flour, white pasta, white rice, plain crackers, low-fiber cereal (<1g fiber)	Brown/wild rice, whole-grain breads/pasta, high-fiber cereal, bread or cereal with nuts or seeds or flax
Meat	Chicken, Turkey, Lamb, Lean pork, Veal, Fish and seafood, Eggs, Tofu	Tough meat with gristle
Legumes	None allowed	Dried peas, dried beans, lentils, any other legumes
Fruits	Fruit juice without pulp, Applesauce, Ripe cantaloupe and honeydew, Peeled apricots and peaches, Canned or cooked fruit without seeds or skin	Raw, cooked, canned fruit with seeds, skin, or membranes (includes berries, pineapple, apples, oranges, watermelon) Raisins/dried fruit
Vegetables	Canned or cooked vegetables without skin or peel (includes peeled carrots, mushrooms, turnips, asparagus tips) Potatoes without skin, Cucumbers without seeds or peel	Corn, Potatoes with skin, Tomatoes, Cucumbers with seeds and peel, Cooked cabbage or Brussels sprouts, Green peas, Summer and winter squash, Lima beans, Onions
Nuts, Nut Butter, Seeds	Creamy (smooth) peanut or almond butter	Nuts including peanuts, almonds, walnuts, Chunky nut butter, Seeds such as fennel, sesame, pumpkin, sunflower
Fats and Oils Small amounts for cooking	Butter, Margarine, Vegetable and other oils, Mayonnaise, Salad dressings made without seeds or nuts	No salad dressing made with seeds/nuts
Soups	Broth, bouillon, consommé, and strained soups, Strained milk or cream-based soup	Unstrained soups, Chili, Lentil soup, Dried bean soup, Corn soup, Pea soup
Desserts	Custard, Plain pudding, Ice cream, Sherbet/sorbet, Jell-O/gelatin without added fruit or red or purple dye, Cookies or cake made with white flour, prepared without seeds, dried fruit, or nuts	Coconut, Anything with seeds or nuts, Anything with added red or purple dye, Cookies or cakes made with whole grain flour, seeds, dried fruit, or nuts
Drinks/Beverages	Coffee, Tea, Hot chocolate, Clear fruit drinks (no pulp), Soda and other carbonated beverages, Ensure, Boost, or Enlive without added fiber	Fruit or vegetable juice with pulp Beverages with red or purple dye
Other	Sugar, Salt, Jelly, Honey, Syrup, Lemon juice	Coconut, Popcorn, Jam, Marmalade, Relishes, Pickles, Olives, Stone-ground mustard

CLEAR LIQUID DIET

YES – OK To Have	NO – Avoid These
Water, Gatorade or clear sports drinks Apple juice, white grape juice, white cranberry juice Limeade or lemonade Black coffee or black tea (sugar only ok) Chicken or Beef Broth Gelatin without toppings (no red, blue, purple)	Milk, Cream or Honey Any red, blue, purple liquids Orange or tomato juice Cream soups-Any soup other than clear broth Oatmeal or cream of wheat Any alcohol

Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: ________________________ Date of Birth: ________
Height:___________ Weight:__________
Ethnicity:________________ Primary Language:_________
Are you hearing impaired: Yes \ No
Do you request for an interpreter/translator?: Yes / No
If yes, please circle for: speech / hearing / written material

Do you have a history of:

Cardiac Problems:

Yes No
- ☐ ☐ High Blood Pressure
- ☐ ☐ Valve Replacement- Date of surgery: ___________
- ☐ ☐ Arrythmia / AFib / Heart Murmur / Palpitations
- ☐ ☐ Angina/Heart Attack (MI) : Date of: ____________
- ☐ ☐ Pacemaker: Date of surgery/checked:___________
- ☐ ☐ Defibrillator (AICD)- call our office
- ☐ ☐ CABG, Bypass, Angioplasty: Date of: _________
- ☐ ☐ Swelling of extremities/edema
- ☐ ☐ High Cholesterol

Respiratory Problems:

Yes No
- ☐ ☐ Asthma, COPD, Emphysema, Other:___________
- ☐ ☐ Sleep Apnea: Do you use a cpap?: Yes No
- ☐ ☐ Difficult airway / history of tracheotomy- call office

GI Problems:

Yes No
- ☐ ☐ Family History of Colon Cancer
  Relationship: _________________
- ☐ ☐ Family History of Colon Polyps
  Relationship: _________________
- ☐ ☐ Family History of Crohns Disease/Ulcerative Colitis? Relationship: ___________
- ☐ ☐ Personal History of Colon Cancer
- ☐ ☐ Personal History of Polyps
- ☐ ☐ Diverticulosis and/or Diverticulitis
- ☐ ☐ Crohns Disease, Colitis, or Celiac Disease
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Bleeding
- ☐ ☐ Constipation or Diarrhea
- ☐ ☐ Stomach or Esophageal Ulcers
- ☐ ☐ Barretts Disease, History of Eosinophilic Esophagitis
- ☐ ☐ Weight Loss/Nausea/Vomiting

Liver/ Gallbladder Problems:

Yes No
- ☐ ☐ Hepatitis A B C
- ☐ ☐ Cirrosis/Liver Disease
- ☐ ☐ Gallbladder Disease/ Surgery

For nursing use only:

R:_________________________________
Cls:___________ Pa: _______________
Egd: __________ F: ________________
P: ________ Zofran:________ S:________
Npo: ___________ A: _________________

Endocrine Problems:

Yes No
- ☐ ☐ Diabetes- Insulin Oral Diet
- ☐ ☐ Thyroid Problems: ____________

Kidney/Prostate Problems:

Yes No
- ☐ ☐ Kidney Disease

Men Only:
- ☐ ☐ Prostate CA
- ☐ ☐ Prostate Enlargement/ BPH

Neurological problems:

Yes No
- ☐ ☐ Stroke
- ☐ ☐ Seizure
- ☐ ☐ Headache/Migraine
- ☐ ☐ Transient Ischemic Attack (TIA)
- ☐ ☐ Vertigo/Balance Issues/ Dizziness

Orthopedic/Musculoskeletal Problems

Yes No
- ☐ ☐ Arthritis
- ☐ ☐ Joint Replacement: ___________

Mental Status:

Yes No
- ☐ ☐ Depression
- ☐ ☐ Anxiety/ Panic Disorders
- ☐ ☐ Confusion

Blood Disorders:

Yes No
- ☐ ☐ Anemia
- ☐ ☐ Clotting Disorders/or Anticoagulant use
- ☐ ☐ Bruises easily

Women Only:

Yes No
- ☐ ☐ Hysterectomy
- ☐ ☐ Mastectomy/ Lumpectomy: R L
- ☐ ☐ Are you pregnant? LMP: ________

Do you have a history of Cancer? ☐ **Yes** ☐ **No**

Type: ____________________________
Treatment:____________________________

Name: ____

Primary Care Physician:__________________________

Primary Care Physician Address: ____

Social History:

Yes No

☐ ☐ Recreational Drug use: Amt: _________

☐ ☐ Alcohol Use: Amt: __________________

☐ ☐ Smoker: Amt: ______________________

Any Metal inside your body/ Aides?

Yes No

☐ ☐ Metal pins/rods/plates?
Location: ___________________________

☐ ☐ Dentures: Full?: U L Partial: U L

☐ ☐ Hearing Aid: R L - Are they in place?: Yes No

PLEASE LIST YOUR SURGICAL HISTORY AND ANY OTHER MEDICAL HISTORY:

____

____

____

1.) Do you have a history of requiring antibiotics prior to dental work or medical procedures? YES NO
2.) Do you have a healthcare proxy? If yes please bring a copy to your procedure if available. YES NO
3.) May we leave a message on your home or work answering machine regarding your care? YES NO

ALLERGIES (please list any allergies and the reactions you experienced)

Food Allergy?: Yes No Please list:____

Medication Allergy?: Yes No Please list: ____

____

Adhesive Sensitivity: Yes No **Egg allergy**:Yes No **Iodine allergy:** Yes No **Latex Allergy:** Yes No

PLEASE LIST ALL OF YOUR MEDICATIONS/VITAMINS (prescriptions and over the counter)

MEDICATION	DOSEAGE	FREQUENCY	LAST DOSE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

Did you take Zofran Prior to your procedure? Yes No ________________________________

This information has been reviewed and updates with the patient just prior to the procedure. Updated 10/7/2022

Gastro Health, P.C./ Middlesex Endoscopy Center LLC.

Consent to Disclose Health Information for Payment, Treatment, and Health Care Operations

These records will be transferred to Electronic Medical Records through Emerson Hospital

Patient Name: ____

Last First Middle

Home Address:____

Street Town State Zip

Date of Birth:__________________ **Gender**:______________________________

Home Telephone:__________________ **Cellular Telephone**:________________________

Emergency Contact:______________________ **Relationship to Patient**:________________

Emergency Contact Telephone:____________ **For Tricare – Sponsor's SSN**:______________

Email address:______________________****provide e-mail address if you would like **Emerson Portal** access

Primary Insurance: __________________ **Primary Care Physician**:____________________

Secondary (If any): ____

How would you like to receive reminders? (circle one) Text Phone Call or Email

***Are we authorized to discuss your appointments, test results, and other pertinent health information with another person?(i.e. spouse, sibling, parent) **Yes** ☐ **No** ☐

If yes, who: ________________________ Relationship to patient: ______________

Acknowledgment of Receipt of Practice's Notice of Privacy Practices:

By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Consent to Disclose My General Health Information:

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also understand that my refusal to sign this consent or revoking this consent may lead to refusal of treatment as permitted by Section 164.506 of the Code of Federal Regulations.

______________________________ ____________________

Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

____________________ ____________________ ____________

Signature of Personal Representative Description of Authority Date

***For Office use only: ID (License has been checked) ☐ ***

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD

In order to protect your identity we request that you bring a valid picture ID and your insurance card to your visit.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it. Special Uses and Disclosures Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post- procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts. Other Uses and Disclosures We may be required or permitted to use or disclose the information even without your permission as described below: Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research. Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order. Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises. Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work- related injuries or illness. Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information. Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. Individual Rights You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law. You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

1. In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
2. You have the right to request that we amend your information.
3. You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
4. You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty- We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices- We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints- If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Marie Russell RN- Center Leader
Middlesex Endoscopy Center, LLC
45A Discovery Way
Acton, MA 01720