AFFILIATED
COLON AND RECTAL SURGEONS, P.C.
Specializing in Colorectal Surgery and Colonoscopy

COLONOSCOPY PACKET

You have advised that you are:

- requesting colonoscopy
- unable to provide this information utilizing the **PATIENT PORTAL**

ENCLOSED PACKET AND INSURANCE CARD, FRONT/BACK

Print the attached packet **in its entirety**. Return **1)** ***PACKET*** **2)** ***COPY OF YOUR INSURANCE CARD-front and back*** and ***3) PHOTO ID.***

DOCTOR REVIEW

After your demographics and medical history have been returned to us, your colonoscopist will review your answers and will write an order for either colonoscopy or an office visit, depending on your responses. A scheduler will call you to arrange for an appointment. After returning **ALL FORMS** via secure FAX, allow us one week to get back to you to schedule the procedure.

BLOOD THINNERS, ASPIRIN, NON-STEROIDAL ANTI-INFLAMMATORY PRODUCTS

If you take medications that thin your blood, your risks of bleeding, after polyp removal/biopsy may increase. Even if you take these medications occasionally, we will want you to discontinue taking them. We may need to obtain medical clearance from your prescribing physician for permission to safely remove you from these medications. **Please do not alter your normal medications until we have determined that it is safe to do so.**

TELEPHONE CALL

Your colonoscopist may call you prior to your exam. If you do not hear from him prior to the test, you will be able to speak with him the morning of the procedure. If you require additional discussions, feel free to schedule an appointment at the office and/or leave a message with the receptionist, who will pass the message onto your doctor.

PREVENTIVE SCREENING VS. DIAGNOSTIC COLONOSCOPY AND PAYMENT

- **Screening:** Generally speaking, screening colonoscopy is done under the **PREVENTIVE** portion of your insurance contract **ABSENT SYMPTOMS**. If your insurance contains a Preventive provision, you may have a 100% benefit that does not affect your deductible, co-insurance and/or co-pay. AGE may be a factor for this benefit. It is your responsibility to check your insurance contract and determine whether preventive screening applies.
- **Diagnostic:** Diagnostic colonoscopy is done for medical reasons. i.e. change in bowel habits, rectal bleeding, abdominal pain, diverticulitis, bowel obstruction etc. This benefit is paid under the **MEDICAL** portion of your policy and may be subject to deductible, co-insurance and/or co-pay.
- **CPT Code:** The code for colonoscopy is 45378. This will vary depending on whether polyps are found and/or biopsied/removed.
- **Insurance Plans Vary:** We are not responsible for insurance carriers and their methods of claim adjudication. Some payors consider a colonoscopy diagnostic if/when polyps are found—even in the absence of symptoms PRIOR to the test. Clarify any questions you may have directly with them!
- ***ALL CHARGES ARE SEPARATE*****: COLONOSCOPIST, FACILITY, PATHOLOGY (if any), ANESTHESIOLOGIST (if utilized). We collect ONLY for the colonoscopist – 2 business days prior to the procedure.** (See also *Easy Pay Authorization*—last page of this packet).

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Colonoscopy Information for the Patient

What is colonoscopy?
Colonoscopy is a safe, effective method of examining the full lining of the colon and rectum, using a flexible, tubular, fiber optic instrument. It is used to diagnose colon and rectal problems and to perform biopsies and remove colon polyps. Most colonoscopies are done on an outpatient basis with minimal inconvenience and discomfort.

Who should have a colonoscopy?
Colonoscopy is routinely recommended to adults 50 years of age or older as part of a colorectal cancer screening program. Your physician may also recommend a colonoscopy if you have had a change in bowel habits, rectal bleeding, personal history of colon or rectal polyps, personal history of colon or rectal cancer, family history of colon or rectal polyps, family history of colon or rectal cancer, personal history of inflammatory bowel disease or if you have concerns about bowel diseases.

How is colonoscopy performed?
In order to perform a colonoscopy, the bowel must first be thoroughly cleared of all stool. This is started one day before the exam with a detailed preparation described by your physician. You may be asked to take the preparation in two doses with the second dose taken in the early morning—4 to 6 hours prior to the colonoscopy. Taking the preparation in two doses has been found to clean out the colon more reliably.

Patients receive intravenous sedation or "twilight sleep" for this procedure. The colonoscope is inserted into the rectum and is advanced to the portion of the colon where the small intestine joins the colon. During a complete examination of the bowel, your physician will remove polyps or take biopsies, as necessary. The entire procedure usually takes less than an hour. Following the colonoscopy, there may be slight discomfort, which quickly improves with the passage of air.

When you present to the facility, you will be checked in by an admission nurse and will then meet with the doctor. He will discuss the intended procedure with you and may examine your heart, lungs, and abdomen. You will also meet the endoscopy nurse, who will be assisting the doctor during the procedure. Following the procedure, you will go to the recovery room, where you will be observed for 30-60 minutes until the effects of the sedative medication wear off. You will not be permitted to return to work, drive, or consume alcohol that day. Most patients are able to eat normally after the test. Ask your doctor when it is safe to re-start aspirin and other blood thinning medications. You will need to make arrangements for transportation home, since it will not be safe for you to drive that day. In addition, someone will need to be available to you for the rest of the day. The day following colonoscopy, you may resume normal activities.

What are polyps and why are they removed?
Polyps are abnormal growths in the colon lining that are usually benign (noncancerous). They vary in size from a tiny dot to several inches. Your doctor cannot always tell a benign polyp from a malignant (cancerous) polyp by its appearance, so he will usually remove polyps for analysis. Because cancer begins in polyps, removing them is an important means of preventing colorectal cancer.

What are the risks of colonoscopy?
Colonoscopy is a very safe procedure with complications occurring in less than 1% of patients. These risks include bleeding, a tear in the intestine, risks of anesthesia and the failure to detect a polyp.

When will I get test results?
Your doctor will describe the results of the procedure to you in the recovery room. If, because of the sedative, you do not recall the conversation, please feel free to call the office and the doctor will again review what happened at the procedure. If biopsies were taken or polyps removed, you will usually be called with results within a week. **If you have not heard the results by then, please give your doctor a call.**

When and where will I have the exam?
Please refer to your scheduling letter for the exact time and location. ***This is done in an OUTPATIENT FACILITY—not in our office.***

LEGAL NOTICE TO PATIENTS

State law A.R.S. 32-1401(25)(f), requires that a physician notify the patient that the physician has a direct financial interest in a "separate diagnostic or treatment agency" to which the physician is referring the patient and/or in the "non-routine goods or services" being prescribed by the physician, and whether these are available elsewhere on a competitive basis. We support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, Doctors Goldblatt and Brown are hereby informing you that they have a direct financial interest in ***SURGICENTERS OF AMERICA***, the "***diagnostic or treatment agency or non-routine goods or services***" named. Furthermore, goods or services that we have prescribed are available competitively at ***BANNER GOOD SAMARITAN HOSPITAL.***

The law provides that you acknowledge that you read/understood this legal disclosure by signing this form in the space provided below. I have read this **Legal Notice to Patients**, and understand the disclosure that it contains.

_____ _____

Signature Date

***** IMPORTANT FOR ALL MEDICARE SCREENING PATIENTS *****

Medicare pays for certain colorectal cancer screening tests. Patients with Medicare Part B coverage, who are age 50 or older, are eligible for colorectal cancer screening.

COLONOSCOPY--HIGH RISK INDIVIDUALS, SCREENING ONLY, G0105

If you are at ***high risk*** for colorectal cancer, Medicare covers a screening colonoscopy ***every 2 years***. You pay 20% of the Medicare approved amount after the yearly Part B deductible. Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps, and if you have a family history of colorectal cancer or polyps, or certain hereditary syndromes. Family history must relate to a sibling, parent or child.

COLONOSCOPY--AVERAGE RISK INDIVIDUALS, SCREENING ONLY, G0121

If you are at ***average risk*** (i.e., not at high risk) for colorectal cancer, Medicare will cover a screening colonoscopy ***every 10 years****, but not within 4 years of a flexible sigmoidoscopy*. You pay 20% of the Medicare approved amount after the yearly Part B deductible.

FLEXIBLE SIGMOIDOSCOPY—SCREENING ONLY, G0104

Screening flexible sigmoidoscopy is covered once ***every 4 years,*** *but not within 10 years of a colonoscopy,* if you are average risk. Medicare pays 100% of the cost. If screening becomes diagnostic, Medicare pays 80% and the patient pays 20% of the Medicare allowed amount.

FOR SCREENING ONLY (i.e. no diagnosis/no history of polyps/cancer) If the time frames mentioned above are not followed, Medicare will not cover the procedure. Medicare may deny the claim because it does not meet the statutory time frame or for other reasons unbeknownst to us. Regardless of the reason for denial, the beneficiary is liable for the entire expense of the procedure.

Beneficiary Agreement:

I have been notified by my physician of the above Medicare colorectal cancer screening policies. If Medicare's requirements are not met, resulting in a denial, I agree to be personally and fully responsible for payment.

_____ _____

Signature Date

Medicare Advantage Plans **aka Medicare REPLACEMENT contracts. Please indicate ONE of the following :**

I hereby confirm that my Traditional, Medicare Fee-for-Service contract ***IS NOT REPLACED*** by a ***Medicare Advantage Plan***.
I hereby confirm that my Traditional, Medicare Fee-for-Service contract ***IS REPLACED*** with a ***Medicare Advantage Plan***.
Not applicable, I do not have Medicare or a Medicare Replacement Product/Medicare Advantage Plan.

_____ _____

Signature Date

PERSONAL INFO

Title Dr. Miss Mr. Mrs. Ms. (select one)

Last Name _____ **First Name** _____ **MI** _____

Previous Name (if any) _____**Address** _____

City _____ **State** _____ **Zip**_____

Hm Phone (_____)_____-_____**Cell Phone** (_____)_____-_____ **Wk Phone** (_____)_____-_____

Email _____ **Primary Care Provider** _____

Referring Provider _____ **DOB (mm/dd/yyyy)** _____ / _____ / _____

Marital Status Divorced Married Partner Single Widowed Legally Separated (select one) **Sex** M F TG

Social Security _____ - _____ - _____ **Employer Name** _____

Employment Status _____ **Occupation** _____

Emergency Contact

Last Name _____ **First Name** _____

Relationship to patient: _____ **Cell Phone** (_____)_____-_____

INSURANCE

Circle any/all that apply: MEDICARE/MEDICARE REPLACEMENT * AHCCCS * INSURANCE * SELF PAY

Primary Insurance *Name and/or Network:* _____

Subscriber Number/Member ID _____ **Group Number** _____

Insured Name, if different than patient _____ **Insured DOB** ____ / ____ / _____

Patient Relationship to Insured _____ **Specialist Co-Pay $** _____

Secondary Insurance *Name and/or Network:* _____

Subscriber Number/Member ID _____ **Group Number** _____

Insured Name, if different than patient _____ **Insured DOB** ____ / ____ / _____

Patient Relationship to Insured _____ **Specialist Co-Pay $** _____

AMERICAN RECOVERY & REINVESTMENT ACT STATISTICAL DATA (select one)

Race Am. Indian/Alaskan Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other

Ethnicity Hispanic or Latino Not Hispanic or Latino Refuse to answer

Preferred Language English Indian (includes Hindi/Tamil) Spanish Russian or _____

*PREFERRED **RETAIL** PHARMACY*

Name _____ **Address/Location** _____

Phone Number (_____)_____-_____ **Fax Number** (_____)_____-_____

*PREFERRED **MAIL ORDER** PHARMACY*

Name _____ **Address/Location** _____

Phone Number (_____)_____-_____ **Fax Number** (_____)_____-_____

REASON FOR VISIT

_____

CURRENT MEDICATIONS

Please list all current prescription medications: None

_____

_____

Do you take aspirin, ibuprofen, or any other non-steroidal anti-inflammatories? Y N

List all current over-the counter medications and/or herbal supplements:

_____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following?

Anal cancer	Y N	Deep vein thrombosis	Y N	Kidney disease/stones	Y N
Asthma	Y N	Dementia	Y N	Lactose intolerance	Y N
Atrial fibrillation	Y N	Depression	Y N	Leukemia	Y N
Bipolar disorder	Y N	Diabetes mellitus	Y N	Myocardial infarction	Y N
Bleeding disorder	Y N	Diabetes, type II	Y N	Parkinson's disease	Y N
Cirrhosis	Y N	Epilepsy/seizures	Y N	Prostate cancer	Y N
Colon cancer	Y N	Fibromyalgia	Y N	Pulmonary embolism	Y N
Colon polyps	Y N	GI disease (ulcers, etc.)	Y N	Rectal cancer	Y N
Congestive heart failure	Y N	Hepatitis B	Y N	Stroke	Y N
COPD	Y N	Hepatitis C	Y N	Thyroid disease	Y N
Coronary artery disease	Y N	High blood pressure	Y N	Vascular disease	Y N
		HIV	Y N		

ALLERGIES

List any drug and/or food and/or latex type allergies and your reaction to them.

_____

SURGICAL HISTORY AND ENDOSCOPIES None

Please indicate your history of **surgeries** and/or **colonoscopies**:

Procedure	Reason	Facility	Year	Physician

NON-SURGICAL HOSPITALIZATIONS None

Please indicate your history of hospitalizations for **non-surgical admissions**:

Reason/hospitalization	Facility	Year	Admitting physician

FAMILY HISTORY No relevant family history Family history unknown

Please describe any relevant GI family history. If family history exists, please indicate the approximate age at which the condition was diagnosed.

	Colon/Rectal Polyps	Colon/Rectal Cancer	Crohn's Disease	Ulcerative Colitis	Breast/GYN Cancer	Age at diagnosis
Father					n/a	
Mother						
Brother					n/a	
Sister						
Son(s)					n/a	
Daughter(s)						
Grandfather					n/a	
Grandmother						

SOCIAL HISTORY

Tobacco Use/Smoking

Please read the following questions and <u>circle the answer</u> which most closely describes your current situation:

Are you a: current smoker former smoker nonsmoker?

How long since you last smoked? N/A < 1 year 1-5 years 5-10 years >10 years

Are you interested in receiving information about smoking cessation? N/A Y N

Alcohol screen

Have you had a drink containing alcohol in the past year? Y N

How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

<u>CARDIOVASCULAR</u>

Chest pain Y N
Shortness of breath Y N
Palpitations Y N

<u>GASTROINTESTINAL</u>

Abdominal pain Y N
Nausea Y N
Vomiting Y N
Constipation Y N
Diarrhea Y N
Rectal bleeding Y N
Change in bowel habits Y N

<u>GENERAL/CONSTITUTIONAL</u>

Weight loss Y N
Weight gain Y N
Chills Y N
Fever Y N
Change in appetite Y N

<u>GENITOURINARY</u>

Painful urination Y N
Difficulty urinating Y N

<u>HEAD AND NECK</u>

Decreased hearing Y N
Difficulty swallowing Y N

<u>HEMATOLOGY</u>

Easy bruising Y N

<u>NEUROLOGIC</u>

Difficulty speaking Y N
Loss of use of extremity Y N

<u>PSYCHIATRIC</u>

Change in personality Y N
Anxiety Y N
Depressed mood Y N

<u>RESPIRATORY</u>

Breathing difficulty Y N
Cough Y N

<u>SKIN</u>

Rash Y N

SURICAL RISK ASSESSMENT

Does your current weight exceed 340 pounds? Y N
Do you have an implanted defibrillator? Y N
Do you have a pacemaker? Y N
Have you been told that you have sleep apnea (temporarily failing to breathe, while asleep)? Y N
If yes, do you HAVE a CPAP machine? Y N
If yes, do you USE your CPAP machine? Y N
Do you oppose blood transfusions for religious or other reasons? Y N
If yes, further explain why you would refuse an emergency transfusion, if one was needed to save your life.

_____

FINANCIAL POLICY:

Thank you for choosing Affiliated Colon and Rectal Surgeons, PC for your care. We welcome you! We are committed to providing the finest care, while minimizing your out-of-pocket expenses. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

INSURANCE: For your convenience, we file medical claims with insurance plans with which we have an agreement, as long as valid insurance information is provided to us. It is your responsibility to make accurate and detailed insurance information is available to us to enable processing of your insurance claim. You are considered self-pay until this information is provided to us.

You are responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between you and your insurance company. All account balances are your responsibility. We collect co-pays and estimated patient co-insurance amounts during office visits. Final payment is due from the patient upon receipt of the first statement from our office.

You are expected to know your insurance benefits including deductible, co-payments and co-insurance percentages. If deductibles are not met, they are to be paid at the time of service with co-payments. If you do not have medical insurance or if Affiliated Colon and Rectal Surgeons, PC is not a participating provider with your insurance carrier, all charges incurred during treatment are due/payable at the time of service. Under certain circumstances, when the estimated amount due exceeds $500, a deposit will be required prior to the service being rendered.

All checks returned for non-sufficient funds will be assessed a $30 charge.

REFERRALS/AUTHORIZATIONS: It is your responsibility to obtain a referral from your primary care physician prior to the scheduled visit if a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

CANCELLATIONS/FEES: If you are unable to keep a scheduled appointment or procedure, it is your responsibility to notify our office 24 hours prior to the scheduled appointment or 48 hours prior to the scheduled procedure. Appointments cancelled after this timeframe may be subject to a cancellation fee**. An additional fees of $25 is applied to requests for medical records and for physicians completing paperwork for patients (i.e. disability, FMLA forms). These fees are NOT covered by insurance and are payable in advance, prior to our completion of these forms.**

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS*: I hereby authorize Affiliated Colon and Rectal Surgeons, PC to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which I am entitled for my treatment and medical services provided to me, to be paid directly to Affiliated Colon and Rectal Surgeons, PC. In the event that payment is made to me, I agree to submit payment in full to provider immediately. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge that I am bound to pay for services rendered, including all costs of collection and reasonable legal fees, should collection become necessary. I have read and understand this Financial Policy and, by signing, am in agreement and accept all terms and conditions described above.*

_____ _____

Signature Date

ACKNOWLEDGMENT OF NOTICE OF HIPPAA PRIVACY PRACTICES:

I hereby authorize Affiliated Colon and Rectal Surgeons, PC to release or procure all information necessary to secure the payments of benefits for treatment purposes or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a copy of this agreement shall be as valid as the original. I understand that HIPAA and privacy policies are available online and in the office. I have reviewed (or have been given the option to review) the Notice of Privacy Practices.

_____ _____

Signature Date

CONSENT TO IMPORT MEDICATION HISTORY:

I understand that ePrescribing (electronic prescriptions) will be utilized, when available. I hereby permit Affiliated Colon and Rectal Surgeons, PC to obtain an electronic history of other medications previously purchased at pharmacies. I understand that obtaining this information is a benefit of ePrescribing and may be utilized for my safety in preventing drug to drug interactions.

_____ _____

Signature Date

EMERGENCY CONTACT INFO AND CONFIDENTIAL MESSAGES CONCERNING MY MEDICAL CARE: (check all that apply)

- ☐ I authorize my physician to leave **BRIEF (ONLY)** confidential medical information on my **cell phone**.
- ☐ I authorize my physician to leave **EXTENDED** confidential medical information on my **cell phone**.
- ☐ I authorize my physician to leave **BRIEF (ONLY)** confidential medical information on my **home answering machine**.
- ☐ I authorize my physician to leave **EXTENDED** confidential medical information on my **home answering machine**.
- ☐ I authorize my physician to release health information to my **Emergency Contact**, as previously indicated.

I understand that my authorization(s) can be revoked, at any time, by my indication in writing of same.

_____ _____

Signature Date

EASY PAY AUTHORIZATION

Our "Easy Pay" credit-card-on-file system gives you the opportunity to place a credit/debit card on file for any balance of charges not paid by your insurance or any non-covered charges, **not to exceed the deductible/co-insurance/copayment amounts.**

Upon authorization, your card will be held on file. When the correct amount is ascertained, you will be notified of the amount due. At that time, you will be given an opportunity to make payment by a different method (check, cash, money order). If, after three days, we are not informed about an alternate payment method, your card will be run.

Cardholder Complete Name: _____

Type of Card: Visa MasterCard Discover Card

Card Number: _____ Exp. _____

Security Code (3 or 4 digits) _____ Billing Zip Code _____

Authorization to Pay:
I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I understand and accept the conditions of the "Easy Pay" plan.

_____ _____

Signature Date

(For Office Use Only)

Patient Account # _____ Date of Procedure _____

Procedure: _____ Est Pt Responsibility: _____

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – ALLOW UNENCRYPTED EMAIL - I understand the risks of unencrypted email and do hereby give permission to **Affiliated Colon and Rectal Surgeons, PC** to send me personal health information via unencrypted email.

_____ _____ _____

Signature Date Printed name

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL I do not wish to receive personal health information via email.

_____ _____ _____

Signature Date Printed name