Atlanta Colon and Rectal Surgery

atlantacolon.com

Oscar M. Grablowsky, M.D.
Sander R. Binderow, M.D.
Jeffrey S. Cohen, M.D.
Jason A. Petrofski, M.D.
Gie Na Yu, M.D.

Atlanta Office
5667 Peachtree Dunwoody Road NE
Suite 330
Atlanta, GA 30342
Phone: 404-252-5669
Fax: 404-252-9473

Canton Office
450 Northside Cherokee Boulevard
Suite 140
Canton, GA 30115
Phone: 770-794-7203
Fax: 770-794-7204

Cumming Office
1505 Northside Boulevard
Suite 1900
Cumming, GA 30041
Phone: 678-341-3764
Fax: 678-341-3769

Marietta Office
780 Canton Road NE
Suite 315
Marietta, GA 30060
Phone: 770-794-7203
Fax: 770-794-7204

Roswell Office
1380 Upper Hembree Road
Roswell, GA 30076
Phone: 678-341-3764
Fax: 678-341-3769

Date: _____

Name: _____

DOB: _____

Please select the doctor you would like to perform your colonoscopy:

Dr. Sander Binderow Dr. Gie Na Yu

Please complete the attached forms and return them to our office using one of the following methods:

Fax: 404-252-9473
Mail: 5667 Peachtree Dunwoody Road
STE 330
Atlanta, GA 30342
ATTN: Your surgery scheduler's name (SEE BELOW)

NOTE: Keeping our patients' protected information confidential is our highest priority, therefore e-mail between patients and Northside employees is not an option.

***** YOU MUST INCLUDE A CLEAR FRONT AND BACK COPY OF YOUR INSURANCE CARD TO SCHEDULE YOUR PROCEDURE*****

All PAGES NEED TO BE FILLED OUT COMPLETELY!
Missing information will be mailed back for completion and may delay the scheduling of your procedure.

If you have any questions or concerns, please contact your surgery scheduler:

Scheduler for Dr. Sander Binderow:
Stephanie Myers (678) 704-8142

Scheduler for Dr. Gie Na Yu:
Shaina Vaughn (678) 704-8143

Reorder #PP0438 (ACRS_E) COLONOSCOPY FORMS PACKET

Our practice is owned by Northside Hospital. We still perform procedures at St. Joseph's Hospital.

5667 Peachtree Dunwoody Road, NE
Suite 330
Atlanta, GA 30342
Phone: 404-252-5669
Fax: 404-252-9473

NORTHSIDE HOSPITAL

Atlanta Colon & Rectal Surgery, P.A.
English - Spanish

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Name of Policy Holder		
Date of Birth of Policy Holder		
Policy/Member ID Number		
Group/Plan Number		
Phone Number		
Effective Date of Policy		

Patient/Guarantor Signature _____ **Date** _____

Reorder #PP0438 (ACRS_E) COLONOSCOPY FORMS PACKET

Reorder #26985 PP0001 (ACRS_E)
Piedmont Graphics 02/19/16

PATIENT REGISTRATION FORM

Our practice is owned by Northside Hospital. We still perform procedures at St. Joseph's Hospital.

5667 Peachtree Dunwoody Road, NE
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Fax: 404-252-9473

NORTHSIDE HOSPITAL

Atlanta Colon & Rectal Surgery, P.A.

English - Spanish

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

Reorder #26703 PP0004 (ACRS_E)
Piedmont Graphics Rev. 05/27/16

ANNUAL ACKNOWLEDGEMENT

Our practice is owned by Northside Hospital. We still perform procedures at St. Joseph's Hospital.

NORTHSIDE HOSPITAL

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at one or more Northside Hospital affiliated medical practices ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to each Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. Each Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to a Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Privacy, Individuals Involved In My Care. I understand that, unless I request confidentiality, the privacy laws allow the hospital to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with you.

Telemedicine I consent to telemedicine consultations as recommended by my physician. My medical information may be discussed with Georgia licensed health professionals through telecommunication technology and, in some cases, a physical examination will be performed. A non-medical technician may be present to assist with the technology and, unless I object, audio or video recordings may be taken during the consultation. I can withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any Medicaid benefits to which you would otherwise be entitled. If I do not consent to a telemedicine consultation, some services may not be available at all Northside locations. All state and federal laws, including privacy and confidentiality, apply to records of the telemedicine consultation.

PHOTOGRAPHY AND RECORDING. Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

Our practice is owned by Northside Hospital. We still perform procedures at St. Joseph's Hospital.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice;
The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and if a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____	_____
Witness Date Time	Signature of Patient or Legal representative Date Time
_____	_____
Interpreter (Note: if phone interpretation used, record interpreter ID#)	Relationship to patient reason patient can't sign

NOTICE OF NON-DISCRIMINATION

Northside Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 404-845- 5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)

Northside Hospital cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee).

Northside Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

Please do not leave blanks. You may respond YES, NO or N/A.

ACRS

ATLANTA COLON AND RECTAL SURGERY, P.A.

English - Spanish

Today's date: _____

Patient Name: _____ **Birth Date:** _____

Race: _____ **Marital Status:** Single Married Widowed Divorced

Employer: _____ **Spouse's Name:** _____

Current Medications & Dosage

(If you do not know the drug name, list the condition)

_____ _____ _____ _____

_____ _____ _____ _____

Please list all your **DRUG ALLERGIES:** _____

Social History

Do you smoke? _____ Frequency _____

Do you consume alcohol? _____ Frequency _____

Do you take drugs? _____ Frequency _____

Past Medical History

Have you ever experienced any of the following conditions? (Please check all that apply.)

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder Infection
- ☐ DVT
- ☐ Pulmonary Embolism
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV +
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pneumonia
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Urinary / Prostate
- ☐ Other History:

Past Surgical History

_____

_____

_____

Have you ever had a colonoscopy? Yes No

If yes, when _____ and results _____

Family Medical History

	Relative	Condition & Age	None
Family History of Cancer			
Family History of Colon Polyps/Tumors			
Family History of Colon Disease			

CURRENT MEDICATIONS & DOSAGE

Please indicate either a yes or no response next to each item. Please do not leave blanks. *For physician purposes, any type of mark (e.g. line, X, check, etc.) will indicate a negative or positive response and not a deferment.*

Review of Systems	No	Yes
Constitutional		
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue/Weakness	☐	☐
Gastrointestinal		
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Ulcers	☐	☐
Change in bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Bleeding with bowel movements	☐	☐
Rectal Pain	☐	☐
Rectal Swelling	☐	☐
Protrusion from rectum	☐	☐
Hemorrhoids	☐	☐
Discharge	☐	☐
Crohn's Disease	☐	☐
Diverticulosis	☐	☐
Irritable Bowel Syndrome	☐	☐
Genitourinary		
Frequent Urination	☐	☐
Burning/Pain with urination	☐	☐
Blood in urine	☐	☐
Incontinence of urine	☐	☐
Bladder infections	☐	☐
Kidney stones	☐	☐
Kidney Disease	☐	☐
Sexual difficulty	☐	☐
Male-Testicle Pain	☐	☐
Prostate Cancer	☐	☐
Female-Vaginal discharge	☐	☐
Female- # of pregnancies _____		
Female-Stool through vagina	☐	☐

	No	Yes
Cardiovascular		
Chest pain	☐	☐
Shortness of breath w/walking	☐	☐
Heart Disease	☐	☐
Hypertension	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
Respiratory		
Chronic coughing	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Musculoskeletal		
Joint Pain	☐	☐
Joint stiffness/swelling	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Difficulty in Walking	☐	☐
Arthritis	☐	☐
Integumentary (skin/breast)		
Rash or itching	☐	☐
Change in skin color	☐	☐
Varicose veins	☐	☐
Breast Pain	☐	☐
Breast lump	☐	☐
Eyes		
Wear glasses/contacts	☐	☐
Blurred or double vision	☐	☐
Eye disease/injury	☐	☐

	No	Yes
Neurological		
Frequent headaches	☐	☐
Migraine Headaches	☐	☐
Light headed/dizzy	☐	☐
Convulsion or seizures	☐	☐
Numbness or tingling sensation	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Epilepsy	☐	☐
Psychiatric		
Memory loss	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐
Ear/Nose/Mouth/Throat		
Hearing loss	☐	☐
Earaches	☐	☐
Chronic sinus problems	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Sore throat	☐	☐
Swollen glands in neck	☐	☐
Hematologic/Lymphatic		
Bleeding or bruising tendency	☐	☐
Anemia	☐	☐
Past transfusion	☐	☐
Blood Disorder	☐	☐
HIV	☐	☐
Endocrine		
Hormone problem	☐	☐
Excessive thirst or urination	☐	☐
Hyper/Hypothyroidism	☐	☐
Diabetes	☐	☐
Hepatitis	☐	☐

How often do you move your bowels? _____ per day _____ per week

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ **Date:** _____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: _____ **Date:** _____

CURRENT MEDICATIONS & DOSAGE

These are the codes we will be using to determine your coverage and benefits with your insurance company. We give your these codes in case you would like to verify your benefits for yourself, however we will be doing this for you on your behalf. If you would like your diagnosis code (ICD-10), please contact the surgery scheduler that applies to you. Otherwise, please sign and return to consent for us to bill your insurance provider.

Colonoscopy Notification Statement
Know what you will owe!

Colonoscopy CPT: 45378

☐ **Diagnostic/Therapeutic Colonoscopy; Diagnosis:** _____
Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.

☐ **Surveillance/High Risk Screening Colonoscopy; Diagnosis:** _____
Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

☐ **Preventive Colonoscopy Screening; Diagnosis:** _____
Patient Is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Who will bill me? You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. Atlanta Colon and Rectal Surgery, PA can only provide you with information associated with our fees.

How will I know what I will owe?

Call your insurance carrier and verify the benefits and coverage by asking the following questions. Codes for your procedure are listed above. (You will need to give the Insurance representative your preoperative CPT and Diagnosis codes.)

1. Is the procedure and diagnosis covered under my policy? ☐ Yes ☐ No

2. Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).

Diagnostic/Medical Necessary Benefits
Deductible:_____ Coinsurance Responsibility: _____

Facility in Network: ☐ Yes ☐ No

Preventative/Wellness/Routine Colonoscopy Benefits:
Are there age and/or frequency limits for my colonoscopy? (e.g. one every ten years over the age of 50, one every two years for a personal history of polyps beginning at age 45, etc)
☐ No ☐ Yes if so;_____

Deductible:_____ Coinsurance Responsibility: _____

3. If the physician removes a polyp, will this change your out of pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit: more out of pocket expenses. Carriers vary on this policy.) ☐ No ☐ Yes

Representative's Name:_____ **Call Reference#:**_____ **Date:**_____

Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening? No. The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

If your insurance plan has a high deductible, you may be asked to make a deposit prior to your procedure. For our fees, deposits, or an explanation of this form, please call our billing department at 404-252-8445. Further information on Colonoscopy can be obtained on our website at www.atlantacolon.com.

_____ _____
Patient Signature **Date**

Colonoscopy Evaluation

Today's Date:_____

*** **Patient:**_____ **Account:**_____

Please choose one of the following reasons for your visit:

☐ Diagnostic/therapeutic colonoscopy

I **have a symptom(s)** and/or diagnosis and need to discuss undergoing a colonoscopy.

☐ Preventive Colonoscopy Screening

I **do not** have any **symptoms**.

I **do not** have any personal or family history of colon cancer, polyps, gastrointestinal disease, etc

☐ High Risk Screening

I **do not** have any **symptoms**.

I **have a personal or family history** of colon cancer, polyps, gastrointestinal disease, etc

Disclaimer: *The preventive services portion of The Patient Protection and Affordable Act only applies to your colorectal screening service. An evaluation and treatment of any sign, symptom, and/or colorectal disease will be processed under your regular insurance benefits; therefore, out of pocket expenses may apply. Please contact your insurance carrier with any questions or concerns regarding your insurance coverage.*

*** _____ _____

Patient Signature Date

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Colonoscopy: What you need to know!

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are many caveats that prevent patients from taking advantage of this provision. One example is a "grandfather" clause; where insurance companies have two years before offering preventative services at no cost. There are now strict and changing guidelines on which colonoscopies are defined as a preventative service (screening). These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost. Patients may be required to pay co-pays and deductibles.

Our practice has created this document to sort through some of the confusion and misinformation out there. Here is what you need to know:

Colonoscopy Categories:

Diagnostic/therapeutic colonoscopy

Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.

Surveillance/ High Risk Screening Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventive Colonoscopy Screening

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Your primary care physician may refer you for a "screening" colonoscopy; however, you may not qualify for the "screening" category. This ls determined in the pre-operative process. *Before the procedure, you should know your colonoscopy category*. After establishing what type of procedure you are having, you can do some research.

Who will bill me?

You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. Atlanta Colon and Rectal Surgery, PA can only provide you with information associated with our fees.

How will I know what I will owe?

Gather your personal coding information

Obtain the preoperative CPT and diagnosis codes as well as the facility name from the scheduler.

Call your Insurance carrier and verify tho benefits and coverage by asking the following questions. (You will need to give the Insurance representative your preoperative CPT and Diagnosis codes.)

1. Is the procedure and diagnosis covered under my policy? ☐ Yes ☐ No

2. Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).

Diagnostic/Medical Necessary Benefits

Deductible:_____ Coinsurance Responsibility:_____

Facility in Network: ☐ Yes ☐ No

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Preventative/Wellness/Routine Colonscopy Benefits:
Are there age and/or frequency limits for my colonoscopy? (e.g. one every ten years over the age of 50, one every two years for a personal history of polyps beginning at age 45, etc) ☐ No ☐ Yes if so;_____
Deductible:_____ Coinsurance Responsibility:_____

3. If the physician removes a polyp, will this change my out of pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit: more out of pocket expenses. Carriers vary on this policy.) ☐ Yes ☐ No

Representative's Name:_____ **Call Reference#:**_____ **Date:**_____

Call the ACRS billing department at 404-252-8445 with any questions or concerns. They are a great source of information and are happy to help if you are struggling to understand your financial obligations. However, it is still necessary for you to first call your insurance company and ask the above questions.

Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening?

No. The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

Patients need to understand that strict government and insurance company documentation and coding guidelines prevent a physician from altering a chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law.

However, if a patient notices an error in the medical record (e.g. date of birth, medication dosage, history notation, etc), he/she may request a correction/amendment by completing the "Request for Correction/Amendment of Protected Health Information" form and forwarding it to the physician's medical assistant. This form can be obtained on our website at www.atlantacolon.com.

What if my Insurance company tells me that ACRS can change, add, or delete a CPT or diagnosis code?

This is actually a common occurrence. Often member service representatives will tell a patient that if only the physician coded it with a "screening" diagnosis it would have been covered at 100%. However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient. Remember, many insurance carriers only consider a patient over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as a "screening" (V76.51).

If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department who will perform an audit of the billing and investigate the information given. Often the outcome results in the insurance company calling the patient back and explaining that the member services representative should never suggest a physician change their billing to produce better benefit coverage.