GASTROINTESTINAL SPECIALISTS, P.C.
Gastroenterology, Hepatology and Therapeutic Endoscopy

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264 W. MAPLE ROAD,
SUITE 200
TROY, MI 48084-5435
(248)273-9930
FAX: (248)273-9931
www.gidrs.com

SCREENING COLONOSCOPY

Dear______________________________:

Our office has been asked to schedule you for a screening colonoscopy. They are usually performed on people who are 50 or older, and are designed to search for and prevent colon cancer. This is different than a diagnostic colonoscopy, which is done to explore symptoms and explain what they might be. If your screening should become diagnostic, such as when the physician removes a polyp or takes a biopsy this may cause a change in your benefits and your insurance company may pay and process the claim differently by applying it to your cost sharing (deductible and coinsurance).

Please fill out the enclosed patient Personal History form and patient information sheet. **PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD, front and back.** Please sign this form and return it along with the other forms in the self addressed envelope that is provided. Your colonoscopy will not be scheduled until all forms have been completed, signed and returned.

PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE PATIENT TO VERIFY BENEFITS AND COVERAGE INFORMATION PRIOR TO THE PROCEDURE. PATIENTS ARE RESPONSIBLE FOR ANYTHING NOT COVERED BY THEIR INSURANCE.

PROCEDURE CODE FOR "SCREENING COLON" G0121
PROCEDURE CODE FOR "DIAGNOSTIC COLON" 45378

GASTROINTESTINAL SPECIALISTS & GASTROINTESTINAL ENDOSCOPY CENTER BILLING PROTOCOL

NOTE: You will receive up to FOUR separate STATEMENTS for your procedure.

1. One of the statements will be addressed from Gastrointestinal Specialists P.C.
2. This is the PROFESSIONAL PHYSICAN'S SERVICES for your procedure.
3. If your procedure requires you to have Biopsies, you may receive a bill from QUEST DIAGNOSTICS.
4. Our office will bill your Insurance for your procedure but you will be responsible for ALL Co pays and Deductibles. Please make arrangements to pay the portion that is not covered by your insurance.
5. You WILL receive another statement form Gastrointestinal Endoscopy Center.
6. This is the FACILITY PORTION of your bill and it takes the place of an outpatient hospital bill.
7. The facility is state licensed and certified by Medicare as an Ambulatory Surgery Center.
8. If your procedure requires you to have sedation, you may receive a bill from ESSENTIAL ANESTHESIA.

I, ______________________________, agree and understand the billing protocol for Gastrointestinal Specialists and Gastrointestinal Endoscopy Center. If I have further questions I will contact and speak to a representative.

Thank you,
Gastrointestinal Specialists
Scheduling Department
-Ext. 3010, Ext. 3036 & Ext. 3034

Gastrointestinal Specialists P.C.

Name: ____ SSN: ____________________
LAST FIRST MIDDLE INT

Birth date: ____________ Age: __________ Sex: M F Marital Status: S M W D

Race: please circle: American Indian, Asian, African American, Caucasian, Declined

Preferred Language: ____________________

Ethnicity: Please circle: Hispanic or Latino, not Hispanic or Latino, Unknown, Declined

Address: ____
STREET CITY ST ZIP CODE

Home Phone #: ( ) ____________________ E-Mail Address: ____________________

Work Phone #: ( ) ____________________ Cell Phone #: ( ) ____________________

Employer: ____________________ Employer address: ____________________

If you were referred by a Physician please list their name and address below.

REFERRING DOCTOR ADDRESS

Please list Primary Care Physician below: (If different from above)

PRIMARY DOCTOR ADDRESS

PRIMARY INSURANCE: ______________ Subscriber Name ______________ Date of Birth ____________

Employer Name: ____________________ Employer Address ____________________
CITY ST ZIP CODE

Relation to insured: Self Spouse Child

Insured's ID Number ____________________ Group # ____________________

SECONDARY INSURANCE: ______________ Subscriber Name ______________ Date of Birth ____________

Employer Name ____________________ Employer Address ____________________
CITY ST ZIP CODE

Relation to Insured Self Spouse Child

Insured's ID Number ____________________ Group # ____________________

OFFICE POLICY REGARDING INSURANCE: Your insurance is a method of reimbursement to you for professional expenses paid to the physician and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charge. You will be responsible for any deductibles, co-payments, or other balances not paid by your insurance, including no call/no show fees without 24 hour notification to cancel/change appointment.

IT IS EXPECTED THAT CHARGES FOR OFFICE VISITS WILL BE PAID AT THE CONCLUSION OF EACH OFFICE VISIT.

AUTHORIZATION FOR DIRECT BILLING: I hereby assign all medical and/or surgical benefits, including major medical benefits (Medicare, private insurance, and other health insurances) to Gastrointestinal Specialists PC. This assignment will remain in effect until revoked by me in writing. A photocopy is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize assignee to release information in my medical record to third party payers to secure payment for services rendered.

SIGNED ______________________________________ DATE ____________________

RESPONSIBLE PARTY ______________________________ DATE ____________________

Gastrointestinal Specialists, P.C. 264 W. Maple Road, Suite 200 Troy, MI 48084 Phone: 248.273.9930 Fax: 248.273.9931

PATIENT'S PERSONAL HISTORY

Date ____________ **Patient Number** ______________

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Age

Address	City/State/ZIP	Home Phone #	Alt. Phone #

Emergency Contact	Relationship to Patient

Family History	Yourself	Mother	Father	Siblings	Children
Colon Polyps					
Colon Cancer					
Ulcerative Colitis/Crohn's					

Medical History

- ☐ Hypertension
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ Pacemaker
- ☐ Defibrillator (AICD)
- ☐ Artificial Valve *or* Endocarditis
- ☐ Liver Disease
- ☐ Kidney Failure
- ☐ Congestive Heart Failure
- ☐ Stomach/Bowel Surgery
- ☐ Sleep Apnea
- ☐ Heart Disease/Angina/MI
- ☐ Other ______________________
- ☐ Heart stent within 6 months

Recent Symptoms

- ☐ Chest Pain
- ☐ Stroke/TIA
- ☐ Persistent / Moderate to Severe Shortness of Breath
- ☐ Loss of Consciousness/Faint

Allergies: ______________________

Medications: ______________________

____

Coumadin: Y / N
└ Prescribed for: __________

Plavix: Y / N **Aspirin:** Y / N **CPAP:** Y / N
Oxygen: Y / N **Insulin:** Y / N

Sedation & Anesthesia

Any problems in the past? Y / N **Explain:** ______________________

Severe nausea/vomiting afterwards? Y / N

GI/Bowel Symptoms

Rectal Bleeding:	Y / N	Anemia/Low Iron:	Y / N
Heme+ Stool cards:	Y / N	Chronic Heartburn/Reflux:	Y / N
Diarrhea:	Y / N	Nausea / Vomiting:	Y / N
Constipation:	Y / N	Trouble Swallowing:	Y / N
Change in Stools:	Y / N		
Alternating BM's:	Y / N		

We would be happy to schedule a consultation with you, if you prefer, prior to your colonoscopy. Consultations prior to a screening colonoscopy are not covered by insurance (unless you have any symptoms), and would be your responsibility.

Would you like to schedule a consultation? Yes / No

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Patient Centered Medical Home Neighborhood Agreement

We appreciate the opportunity to serve you and partner with you to help achieve your best health. This can happen by using us as your Patient Centered Specialty Care Doctor. We work with your Primary Care doctor who is your Patient Centered Medical Home to help you feel better. Below are some important things to remember.

PATIENTS please:

- Verify insurance, primary care doctor, address, and phone number with receptionist when you check in.
- Verify medication list with medical assistant when she takes you back to the room.
- Make and keep all appointments needed.
- If you need to cancel an appointment, please call to cancel as soon as possible. Make sure you reschedule another one right away.
- Follow the plan we discussed during your appointment.
- Ask questions until you know what you need to do when you leave our office.
- Know your insurance and what it covers.

SPECIALIST DOCTOR:

- We will ask you who your Primary Care doctor is. We will let him/her know about your care as soon as possible.
- We will talk with you about your health and what you need to do to take care of yourself.
- We will talk to you by phone and in the office to answer your questions.
- Electronically prescribe your medications to ensure they are accurate and available to you promptly.
- Inform you of all positive test results.
- Provide you 24 hour access to a clinical decision-maker by phone.

Patient Name: ______________________________

Signature: ______________________________

Date: ______________________________

- o **Declined, No Thanks**

Revised 3/2014