GASTRO HEALTH

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You are scheduled for a FIBROSCAN on:__________________ at: ______________

The test is performed in our office at 475 Franklin St. Suite 110 in Framingham.

****A $50.00 cancellation fee will be billed directly to the patient for any appointment not cancelled with a 48 hour notice.****

What is a FIBROSCAN?

A Fibroscan is a non-invasive, painless test using an ultrasound probe that measures the health of your liver. It measures the liver's elasticity (stiffening/scarring) and steatosis (fatty liver).

During the procedure, you will be asked to lie on your back with your arm raised behind your head. This procedure normally does not take more than 30 minutes.

****This test is not to be done if you are pregnant, or have any implanted device such as a pacemaker, defibrillator, implanted insulin pump, cochlear implant, etc. Please let us know asap if you have any of these devices or are pregnant.**

PREPARATION for test:

1. **Nothing by mouth 3 hours prior to the test (only plain water is permitted)**
2. Wear a loose-fitting shirt and pants
3. You may drive yourself to and from the test. You do not need someone to accompany you.
4. There are no side effects and you may return to your normal activities following the test.

Gastro Health

ADVANCE BENEFICIARY NOTICE

NOTE: You need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the services that are described below. The fact that your insurance may not pay for a particular service does not mean that you should not receive it. There may be a good reason for your doctor recommending it.

Services:

- ______ **Small Bowel Capsule Endoscopy – Code 91110 - $2500.00**
- ______ **SIBO/Glucose Breath Test/KBT – Code 91065 - $300.00**
- ______ **Lactose Breath Test – Code 91065 - $300.00**
- ______ **Fructose Breath Test – Code 91065 - $300.00**
- ______ **Urea Breath Test – H.Pylori – Code 78267 - $150.00 – acquisition**
  - **Code 78268 - $300.00 – analysis**
  - **Total $450.00**
- ______ **Fibroscan – Code 76981 - $225.00**

Diagnosis:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself.

You may wish to contact your insurance company directly and give them the information as outlined above regarding the service. The description of the service, the procedure code which will be billed, as well as the fee that would be charged may be given to them for prior approval.

The office will submit the claim to your health insurance. You will, however, be fully and personally responsible for payment of this service if the insurance company denies payment. **No appointment will be made without this signed authorization.**

I want to receive these services. I agree to pay personally for any services denied by my insurance carrier.

______________ ____

Date **Signature of Patient**