GASTRO HEALTH

H. PYLORI BREATH TEST

You are scheduled for a H.Pylori Breath Test on:_____ at: _____in suite 110

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

1. **2 weeks prior to test:** you need to be off all antibiotics, probiotics, proton pump inhibitors (PPI) and/or Bismuth type medications. Note: Bismuth medications are Pepto-Bismol and all generic forms.

   Date to Stop medication: _____

   Date stopped medication _____

PPI include:

Generic Name	US Brand Name
Omeprazole	Prilosec
Lansoprazole	Prevacid
Rabeprazole	Aciphex
Sucralfate	Carafate
Esomeprazole	Nexium
Pantoprazole	Protonix

2. **Day of Test:** ***Nothing by mouth for 1 hour prior to test, no gum, breath mints, tooth paste and mouth wash.***

Note: You can continue to take H2 Blockers, such as Tagamet, Zantac, Axid, Ranitidine and Pepcid and Antacids, such as Maalox, Rolaids, Tums, Mylanta, and Gelusic.

It is critical that you follow all of the above instructions for the test to accurately determine if you are infected.

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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 83014 - $50.00 – acquisition**
  - **Code 83013 - $150.00 – analysis**
  - **Total $200.00**
- _____ **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**