GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

FAST TRACK SCREENING COLONOSCOPY INSTRUCTIONS

NOTE: Your Insurance may not pay for your Colonoscopy if you are under age 50.

It is your responsibility to contact your insurance company to find out if you are eligible for your Screening Colonoscopy Benefit.

Should you decide to have your Screening Colonoscopy and your insurance company denies your claim, you will be responsible for the charges associated with your procedure.

Please complete all forms. Attach any additional documents and fax, mail or deliver to the appropriate office location below:

Catonsville:
700 Geipe Road, Suite 230
Catonsville, MD 21228
Phone: 410-247-7500
Fax: 410-247-4227

Columbia:
10710 Charter Drive, Suite 110
Columbia, MD 21044
Phone: 410-992-9797
Fax: 410-730-0942

Thank you for contacting our office for a Fast Track Screening Colonoscopy. This process will potentially allow you to have your procedure without first being seen by one of our gastroenterologists. Please be aware this program is for individuals without any gastrointestinal symptoms with a medical history that meets the guidelines for the program.

1. **A copy of your insurance card(s), front and back.**
2. **A copy of your referral from your insurance carrier, if required by your insurance policy.**
3. **A copy of your most recent history and physical or office visit notes from your primary care physician (PCP) and/or a copy of the office notes from your referring physician. Your PCP can also fax the information to our office.**

Upon receipt of your documents, a physician will evaluate your medical information to ensure you are a candidate for a Fast Track Screening Colonoscopy. Our staff will contact you within 10-14 days to schedule your procedure, or if you do not qualify, schedule your office visit. If you do not receive a call in 10-14 days, please call our office.

Confirmation of your scheduled procedure (or appointment) as well as instructions for your procedure will be mailed to you. Dietary and bowel preparation instructions will be included.

Thank you for selecting Gastro Health for your medical care.
If you have any questions concerning your procedure or the process, please contact us!

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

Patient Name: **Account Number:**

Advance Beneficiary Notice of Non-covered Services

NOTE: Your Insurance may not pay for your Colonoscopy if you are under age 50.

It is your responsibility to contact your insurance company to find out if you are eligible for your Screening Colonoscopy Benefit.

Should you decide to have your Screening Colonoscopy and your insurance company denies your claim, you will be responsible for the charges associated with your procedure.

Signing below means that you have received and understand this notice.

Signature:	**Date:**

Witness_____

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

FAST TRACK SCREENING CHECKLIST

PATIENT NAME _____ DOB _____

REFERRING PHYSICIAN _____ GI PHYSICIAN PREFERENCE _____

Please answer the following questions to assess your eligibility for a Fast Track Screening Colonoscopy.

If you answer yes to any of these questions, you may need an office visit before your procedure is scheduled.

Yes	No	
❑	❑	1. Are you over 65?
❑	❑	2. Do you weigh more than 315 lbs and have a BMI above 45? Height _____ Weight _____ BMI _____
❑	❑	3. Have you had a change in your medical history in the last year? **IF YES, PLEASE PROVIDE DATE (MONTH AND YEAR).** ❑ Heart attack _____ ❑ Irregular heartbeat _____ ❑ Coronary artery stent replacement _____ ❑ Stroke _____ ❑ Seizure _____
❑	❑	4. Have you ever seen a cardiologist (heart doctor)? If yes, what is the doctor's name? _____
❑	❑	5. Do you have any current gastrointestinal symptoms that need to be addressed with the physician prior to the procedure? ***(This includes heartburn, abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia.)***
❑	❑	6. Are you currently on dialysis, have a defibrillator, pacemaker, artificial heart valve, breathing issue requiring home oxygen, or being monitored by a respiratory doctor? **(Please circle all that apply.)**
❑	❑	7. Are you on any blood thinners other than aspirin?
❑	❑	8. Will you have any contraindications (problems) stopping any of your medications 5-7 days prior to your procedure? ***(This includes Aspirin, Ibuprofen, Motrin, Advil, or any other non-steroidal medication.)***
❑	❑	9. Are you a diabetic? If yes, do you have an insulin pump? ❑ Yes ❑ No

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

PATIENT DEMOGRAPHICS AND INSURANCE FORM

TREATING DOCTOR (PLEASE CHECK) ❑ ABBAS ❑ ABERNATHY ❑ ALEX ❑ ANDORSKY ❑ BANEGURA ❑ CROSSE ❑ JOY ❑ P. KIM ❑ MOUSSAIDE ❑ NARAYEN ❑ RAVENDHRAN ❑ SALAS ❑ SARDANA ❑ SOLOMON ❑ VAN DEN BROEK

TODAY'S DATE	❑ DR. ❑ MRS. ❑ MS. ❑ MISS ❑ MR.	FIRST NAME	MIDDLE	LAST	DATE OF BIRTH	SEX ❑ M ❑ F
STREET ADDRESS		CITY	STATE	ZIP		

WHEN WE CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT, SHOULD WE CONTACT YOUR? ❑ HOME PHONE ❑ CELL PHONE	HOME PHONE	WORK PHONE
	CELL PHONE	EMAIL ADDRESS

MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	ETHNICITY ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑ DECLINED ❑ OTHER_____
RACE ❑ AMERICAN INDIAN ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ WHITE ❑ DECLINED ❑ OTHER_____	PRIMARY LANGUAGE

EMPLOYER	IN CASE OF EMERGENCY, NOTIFY	DAYTIME PHONE

PERSON FINANCIALLY RESPONSIBLE ❑ SELF ❑ PARENT ❑ OTHER_____	IF DIFFERENT THAN PATIENT: NAME	PHONE NUMBER
	ADDRESS	

PRIMARY INSURANCE INFORMATION

COMPANY NAME	PHONE NUMBER
POLICY NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER	
EMPLOYER	

POLICY HOLDER'S DATE OF BIRTH	SEX ❑ M ❑ F	RELATIONSHIP TO INSURED

SECONDARY INSURANCE INFORMATION

COMPANY NAME	PHONE NUMBER
POLICY NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER	
EMPLOYER	

POLICY HOLDER'S DATE OF BIRTH	SEX ❑ M ❑ F	RELATIONSHIP TO INSURED

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN (RP)	PRIMARY CARE PHYSICIAN (PCP)
PHONE NUMBER	PHONE NUMBER

HOW WERE YOU REFERRED TO OUR PRACTICE?
❑ PRIMARY CARE PHYSICIAN ❑ OTHER PHYSICIAN ❑ OUR WEBSITE ❑ FRIEND ❑ RELATIVE ❑ OTHER_____

PHARMACY INFORMATION

PREFERRED PHARMACY	PHONE NUMBER
ADDRESS	

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

MEDICAL HISTORY FORM

PATIENT NAME _____ DOB _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

INSTRUCTIONS: This questionnaire will assist us in understanding your medical condition. Please answer all the questions fully and print legibly. If you are uncertain about any questions, please use a question mark (?)

CHECK ONE OR MORE OF THE FOLLOWING REASONS THAT APPLY:

❑ **NONE** Are you constipated? ❑ Yes ❑ No Average # of bowel movements per day/week: ____/____

SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET
❑ Abdominal pain		❑ Change in bowel habits		❑ Incontinence of stool	
❑ Abnormal CT scan or ultrasound		❑ Chest pain		❑ Nausea and/ or vomiting	
❑ Abnormal liver enzymes		❑ Constipation		❑ Painful swallowing	
❑ Anemia		❑ Diarrhea		❑ Rectal bleeding	
❑ Black, tarry stools		❑ Difficulty Swallowing		❑ Vomiting blood	
❑ Bloating/Gas		❑ Excessive Belching		❑ Weight loss	
❑ Blood in a stool on test		❑ Heartburn / GERD		❑ Other	
		❑ Hepatitis / Jaundice			

PAST MEDICAL ILLNESSES Check if you have a history of any of the following. Please check all that apply.

❑ **NONE**

GASTROINTESTINAL

❑ Barrett's esophagus	❑ Colon polyps	❑ Fatty liver	❑ Pancreatitis
❑ Celiac disease	❑ Crohn's disease	❑ Hiatal hernia	❑ Stomach ulcer
❑ Cirrhosis	❑ Diverticulitis	❑ H. Pylori	❑ Ulcerative colitis
❑ Colon cancer	❑ Diverticulosis	❑ Irritable bowel (IBS)	❑ Other_____

CARDIOVASCULAR

❑ Atrial fibrillation	❑ Coronary artery diseases	❑ High blood pressure	❑ Other_____
❑ Chest pain	❑ Extra heart beats (PVC)	❑ Slow heart beat	
❑ Congestive heart failure	❑ Heart attack	❑ Supraventricular tachycardia	

PULMONARY

❑ Asthma ❑ Sleep apnea
❑ I use CPAP machine ❑ Other_____
❑ Emphysema (COPD)

ENDOCRINE

❑ Diabetes
❑ Insulin pump
❑ Other_____

NEUROPSYCHIATRIC

❑ Stroke
❑ TIA (mini-stroke)
❑ Other_____

GENITOURINARY

❑ Kidney disease
❑ Renal failure
❑ Other_____

HEMATOLOGIC

❑ Bleeding disorders ❑ Other_____
❑ Clotting disorders
❑ Low platelets

ONCOLOGY

Any malignant tumors not previously mentioned
_____

CONTINUED

DIAGNOSTIC TESTS Check the boxes below if you have had any of the following tests and indicate the date.

❑ **NONE**

	Date		Date
❑ Barium enema		❑ MRI (abdomen/pelvis)	
❑ Colonoscopy		❑ Ultrasound (abdomen)	
❑ CT scan (abdomen/pelvis)		❑ Upper Endoscopy (EGD)	
❑ Flexible sigmoidoscopy		❑ Upper GI Series	

PAST SURGICAL HISTORY Check the boxes below if you have had any of the following surgeries and indicate the year.

❑ **NONE**

	Year		Year		Year
❑ Appendix surgery		❑ Heart catherization		❑ Hysterectomy	
❑ Back/spine surgery		❑ Heart defibrillator		❑ Neck surgery	
❑ Bariatric surgery		❑ Heart pacemaker		❑ Rectal surgery	
❑ Breast surgery		❑ Heart stenting		❑ Other	
❑ Heart bypass		❑ Heart valve replacement			
❑ Gall bladder removal		❑ Hernia repair			

ALLERGIES List all allergies, including medication allergies (also include over-the-counter medications) Indicate reaction to allergy (ie. rash, hives, shock, etc.) and if hospitalized for treatment.

❑ **NONE**

Allergy	**Reaction**	
		Hospitalized ❑ Yes ❑ No
		Hospitalized ❑ Yes ❑ No

Check all statements which apply

❑ I have had prior difficulties with anesthesia
❑ I have a latex allergy
❑ I require antibiotics prior to surgery
❑ I have an allergy to Iodine or IV Contrast

MEDICATION LIST List medication names, doses and how often taken. Include "over-the-counter" medications.

❑ **NONE**

Medication Name	**Dose**	**Frequency taken (eg: once per day)**

If on a blood thinner, please check ❑ Coumadin ❑ Warfarin ❑ Plavix ❑ Pradaxa ❑ Other_____

FAMILY HISTORY ❑ **NONE**

	Relationship/Age Diagnosed		Relationship/Age Diagnosed		Relationship/Age Diagnosed
❑ Breast cancer		❑ Pancreatic cancer		❑ Esophageal cancer	
❑ Liver cancer		❑ Colon polyps		❑ Ulcerative colitis	
❑ Celiac disease		❑ Stomach cancer		❑ Kidney cancer	
❑ Ovarian cancer		❑ Crohn's disease		❑ Uterine cancer	
❑ Colon cancer		❑ Thyroid cancer			

SIGNATURE

DATE

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

FINANCIAL POLICY

FOR PATIENTS WITH INSURANCE: Co-payments, coinsurance and/or deductibles are the responsibility of the patient or responsible party and due at the time of service. It is the patient's responsibility to obtain a written referral and authorization if their insurance carrier requires the same. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.

FOR PATIENTS WITHOUT INSURANCE: I understand that payment for services rendered by Gastro Health is due and payable in full at the time services are rendered, unless prior arrangements have been made with an employee of Gastro Health.

IN THE EVENT: The Patient submits payment by check and that check is returned for any reason by the Bank, Gastro Health will add $30.00 to the balance owed by the Patient or Responsible Party.

NO STATEMENT BY AN EMPLOYEE or agent of Gastro Health will contradict, void, or nullify this agreement, nor shall the patient rely on any statements or opinions made by Gastro Health that Patient's insurance carrier will pay the bill.

PAYMENTS: Unless other arrangements are approved by Gastro Health in writing, the balance on your statement is due and payable when the statement is issued, and past due if payment is not received within 60 days after adjudication by your insurance carrier.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the steps necessary to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collection costs that are incurred, including attorney fees and court costs, if applicable. Any balance unpaid after 60 days from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney and/or collection agency, if Gastro Health has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and that your account is delinquent with Gastro Health will become a matter of public record.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I give my consent for treatment and authorize the release of clinical information to other medical professionals who have need of such use for the provision of my care. **I hereby authorize Gastro Health** to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf. **Authorization is hereby given to Gastro Health** to submit all claims directly to my insurance company on my behalf and authorize my insurance carrier to forward payment directly to Gastro Health.

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide information below on how we should contact you.)

I hereby authorize Gastro Health to communicate information regarding my evaluation, diagnosis, treatment and billing to/with:

❑ My spouse/family member/other _____ (NAME) _____ (INITIALS)

❑ My spouse/family member/other _____ (NAME) _____ (INITIALS)

❑ If, when calling, we reach an answering machine or voicemail message, may we leave a message? ❑ Y ❑ N _____ (INITIALS)

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I authorize Gastro Health to obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of my treatment.

AUTHORIZATION AND ACKNOWLEDGMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Gastro Health as described above, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested in the section titled Confidential Communication of Personal Health Information, that I give authorization to Gastro Health to obtain my Medication History as indicated above and that I have received a copy of the Gastro Health Notice of Privacy Practices.

_____ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____ DATE

_____ IF RESPONSIBLE PARTY, PLEASE PRINT NAME

_____ RELATIONSHIP TO PATIENT

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

APPOINTMENT CANCELLATION / NO-SHOW POLICY

Gastro Health is privileged to provide medical and endoscopic treatment for our patients. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's needs for office visits and procedures in a timely manner. This requires careful planning and coordination amongst many individuals in our office. We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment or procedure without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, we have developed this policy regarding failure to keep appointments or canceled appointments without adequate notice. This policy will also apply to scheduled procedures, but the monetary consequences will be greater. We respectively request your understanding and agreement to our policy as is stated below.

OFFICE VISITS

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than **24 HOURS** in advance of their appointment will be charged a fee of $50.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday. If an established patient fails to keep three appointments or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

PROCEDURES

Any patient who fails to keep an appointment for a procedure (upper endoscopy, colonoscopy, flexible sigmoidoscopy, endoscopic retrograde cholangiopancreatography) or remicade infusion; or who cancels or reschedules an appointment less than **48 HOURS** in advance of their procedure or infusion will be required to pay $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Thursday.

If an established patient fails to keep two appointments or fails to give adequate notice on two occasions, their primary care physician will be notified, and the practice will have the right to dismiss that patient from the practice.

FEES

All fees charged by Gastro Health pursuant to this No-Show / Cancellation Policy are not payable by your insurance company.

All fees are payable on or at your next office appointment with your Gastro Health physician or within 30 days of receipt of billing statement from Gastro Health for that fee, whichever is earlier.

Please remember that it is your responsibility to make certain that we have updated and/or accurate phone numbers and addresses so that we may contact you promptly.

Thank you for your consideration and understanding of our policy.

PATIENT SIGNATURE _____ DATE _____

GASTRO HEALTH

FORMERLY DIGESTIVE DISEASE ASSOCIATES

SOCIAL HISTORY

MARITAL STATUS

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Civil Union ❑ Unknown

❑ Other_____

ALCOHOL

❑ None ❑ Occasionally ❑ Daily

CAFFEINE

❑ None ❑ Occasionally ❑ Daily

TOBACCO

Smoking Status:

❑ Current every day smoker ❑ Currently smokes some days ❑ Heavy tobacco smoker

❑ Light tobacco smoker ❑ Smoked, current status unknown ❑ Former smoker

❑ Never smoked ❑ Unknown if ever smoked

	Started	Quit	Quantity	Frequency
❑ Cigarettes				Times / Month
❑ Cigar				Times / Month
❑ Chewing Tobacco				Times / Month

DRUG USE

❑ None

❑ Recreational

❑ IV or Intranasal drugs

Type_____

Quantity	Number	Frequency
		Times / Month
		Times / Month
		Times / Month

EXERCISE

❑ None

❑ Regular

❑ Occasional

Type_____