

COLON RECTAL SURGICAL ASSOCIATES, LLC

PATIENT REGISTRATION

WELCOME TO OUR PRACTICE!

ACCOUNT # _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

HOME ADDRESS _____ ZIP _____

SEX ___M___F HOME PHONE _____ WORK PHONE _____ BIRTH DATE _____

SOCIAL SECURITY # _____ MARITAL STATUS ___S___M___W___D

EMPLOYER _____ EMPLOYER'S ADDRESS _____

NEXT of KIN, SPOUSE, &/or RESPONSIBLE PARTY _____ PHONE _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

PRIMARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER'S NAME _____ POLICY HOLDER BIRTH DATE _____

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

PHONE # _____ RELATIONSHIP TO PATIENT ___SELF___ PARENT ___SPOUSE___ OTHER

POLICY HOLDER'S EMPLOYER _____ EMPLOYER'S PHONE # _____

SECONDARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER'S NAME _____ POLICY HOLDER BIRTH DATE _____

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

PHONE # _____ RELATIONSHIP TO PATIENT ___SELF___ PARENT ___SPOUSE___ OTHER

POLICY HOLDER'S EMPLOYER _____ EMPLOYER'S PHONE # _____

I recognize and agree that I am responsible for payment of all medical services provided for me or my legal dependent by Drs. Berg/Vachon/Zalucki/Cifello/Somerville/Akbari, regardless of my insurance coverage, and that payment is due within thirty (30) days of the date payment is requested. I agree that in the event that my account must be turned over for collection, I will be responsible for collection fees, attorney fees, court costs and interest.

I hereby authorize Colon Rectal Surgical Associates, LLC to apply for benefits for any covered services rendered and I request the direct payment of authorized medical benefits (including Medicare, Medigap, Major medical benefits) be made to **Colon Rectal Surgical Associates, LLC** for any services furnished by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I permit a copy of this authorization to be used in place of the original copy. This agreement will remain in effect until I revoke in writing, this authorization.

SIGNATURE

SEAL

DATE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are hundreds of different insurance policies and managed care options. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in colon and rectal care, not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Does your insurance require a referral from your primary care physician? Have you obtained that referral? The referral must be received by the time of your visit or you will be required to pay for the service. Many managed care plans do not issue referral numbers after the date of service. Look at your insurance card. A toll free number is usually listed on the back of the card. Someone with your insurance company should be able to answer your questions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks and balances older than thirty (30) days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advanced notice.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

- I hereby understand that I am responsible for giving "Colon Rectal Surgical Associates, LLC" the correct insurance information.
- I am also responsible for obtaining the proper referral.
- I agree to pay for services for which I failed to obtain a proper referral.
- I agree to pay for non-covered services under my insurance plan.
 - I have read, understand and agree to the above information.

Signature: _____ SEAL

Date: _____

COLON RECTAL SURGICAL ASSOCIATES, LLC

**Howard K. Berg, M.D. James J. Zalucki, M.D. Debra A. Vachon, M.D.
Vincent Cifello, M.D. Justin C. Somerville, M.D. Robert Akbari, M.D.**

COLON AND RECTAL CANCER SCREENING ASSESSMENT

Name: _____ **Age:** _____ **Date:** _____ **Referring MD:** _____

Are you experiencing? (If YES, please explain)

- Y N **Rectal Bleeding** _____
- Y N **Change in Bowel Habits** (narrowed stools, new-onset constipation or diarrhea) _____
- Y N **Persisting Abdominal Pain** _____
- Y N **Unexplained Weight Loss** _____
- Y N **Anemia** _____
- Y N **Other problems with your bowels** _____

Have you?

- Y N **Family Members who have had Colon Cancer or Polyps?** _____
- Y N **Personally had Colon Cancer or Polyps?** _____
- Y N **Personally had Ulcerative Colitis, Breast Cancer, Uterine Cancer, or Ovarian Cancer** _____

Previous Colon Examinations (Colonoscopy, Sigmoidoscopy, Lower GI/Barium Enema)? When?

Medical Conditions (High Blood Pressure, Diabetes, Sleep Apnea, Need Antibiotics for Dental procedures or Surgery, etc.) _____

Prior Surgeries: _____

Allergies (including Latex): _____

Medications (including Aspirin, Coumadin, Plavix, and blood thinners): _____

(((To be filled out by Physician)))

PEx: Temp _____ BP _____ HR _____ RR _____ HT _____ WT _____ (__ See Nursing Flow Sheet)

Mental status: Oriented to person, place, time: __Y__N__ Recent & Remote Memory: __nl__impaired

CV: Heart sounds: __nl__Murmur Abd aorta __nl__AAA

Lungs: Effort: __nl__ Intercostals retractions, Accessory muscles, Diaphragmatic

Ascultation: __nl__ Wheezes, Rhonchi, Rubs, Rales

Abd: Tender: __N__Y__ Distended: __N__Y__ Masses: __N__Y__ Liver/Spleen: __nl__enlarged

Hernia: __N__Y__ Bowel sounds: __nl__hyper_hypo

Colon Cancer Risk: High (G0105 , 45385-GA) **Plan:** __ Proceed with Colonoscopy (Fleets, Nulytely)

Ave (G0121, 45385-GA) __ Other: _____

Reviewed by: _____ (Physician Signature)

COLON RECTAL SURGICAL ASSOCIATES, LLC

Howard K. Berg, M.D. James J. Zalucki, M.D. Debra A. Vachon, M.D.
Vincent Cifello, M.D. Justin C. Somerville, M.D. Robert Akbari, M.D.

CONSENT FOR COLONOSCOPY

Name of Patient: _____ Date: _____ AM/PM

1. My doctor has recommended the following procedure: **COLONOSCOPY WITH POSSIBLE POLYP REMOVAL AND/OR BIOPSY**. A Colonoscopy is a way of directly inspecting the inside of the colon and rectum. A long, flexible, lighted tube (colonoscope) is used to diagnose problems of the colon and rectum, perform biopsies, and remove colon polyps.

2. **CONSENT**: I consent to have the procedure described above performed by my doctor as the surgeon-in-charge. The surgeon-in-charge may designate other medical personnel to assist in the procedure. I consent to the photographing of appropriate portions of my colon or anorectum, for medical or educational purposes. I consent to the administration of such analgesics, sedatives, and/or anesthetics as deemed advisable with the exception of any stated allergies. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor, or employee of the facility, I consent to testing for HIV and Hepatitis.

3. **INDICATIONS FOR PROCEDURE**: The reason for this procedure is to evaluate your symptoms, an abnormal test, or to determine whether a polyp, cancer, or inflammation may be present.

4. **METHOD, ALTERNATIVES, AND RISKS**: The doctor has explained the details of the procedure (including conscious sedation), alternatives, outcomes, and associated risks and possible complications to me, to my satisfaction. Alternatives include: No evaluation; X-ray evaluation (Barium Enema); or Empiric treatment with medication. I understand that every conceivable risk and complication could not be explained to me. The main complications specific to this procedure are as follows:

 - A. **BLEEDING**: (Approximate risk less than 0.5%). This may result in the need for a blood transfusion. This carries the risks of transfusion reaction, hepatitis, or AIDS (Acquired Immune Deficiency Syndrome).

 - B. **PERFORATION (TEAR/PUNCTURE)**: (Approximate risk less than 0.5%). On rare instances the bowel may be injured; requiring hospitalization, bowel rest, IV fluids, and antibiotics. Surgery may be needed to repair the injury. This may involve direct repair of the perforation, removal of a portion of the colon, and/or a temporary ostomy (opening of the bowel onto the skin with stool emptying into a bag).

 - C. **INFECTION**: A biopsy, polyp removal, or small tear may result in an infection (abdomen/pelvis, colon/rectum, heart valves, or other sites) which could require hospitalization and antibiotics.

 - D. **ALLERGIC REACTION TO MEDICATIONS** (sedating medicines, antibiotics, etc.)

 - E. **DEVELOPMENT OF ABNORMAL HEART RHYTHM, HEART ATTACK, LOW OR HIGH BLOOD PRESSURE**

 - F. **RESPIRATORY FAILURE**: **Inability** to adequately breathe or asthma.

- 5. **NO GUARANTEE:** No guarantee has been made to me about the outcome of the procedure. I understand that sometimes it is not successful. Occasionally, the rectum and entire colon may not be able to be examined (incomplete colonoscopy) and additional testing, such as a Barium Enema, may be necessary. Additionally, the problem may not be seen (i.e. a polyp, cancer, etc. may be missed) or the polyp not able to be retrieved for evaluation. Undergoing a colonoscopy does not guarantee that you will not develop a colon or rectal cancer in the future.
- 6. **COMPLICATIONS AND UNFORESEEN CONDITIONS:** I consent to any additional procedure that good medical judgement indicates should be performed to deal with any complication or unforeseen condition, if it seems medically undesirable to delay the procedure until my further written consent has been obtained.
- 7. **TISSUE:** I consent to the study, use, and disposal by Hospital of any tissue or parts, which may be necessary to remove.
- 8. **PREGNANCY:** I certify that to the best of my knowledge I am not pregnant. I understand that a colonoscopy, surgery, or X-rays may harm unborn children. I understand that by signing this consent form I am agreeing to inform my doctor immediately if I learn I am pregnant after signing this form.
- 9. **CERTIFICATION:** By signing this form I certify that I have had my eighteenth (18th) birthday or I am married, pregnant or a parent.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS.

PATIENT'S SIGNATURE:

WITNESSED BY:

Patient Name

Date

Date

I, or my staff, have explained the above information to the patient, and believe that he/she understood our discussion. The patient was given a Colonoscopy educational pamphlet, and offered a copy of this consent form.

 Howard K. Berg, M.D., FACS, FASCRS
 Vincent Cifello, M.D., FACS, FASCRS
 Justin C. Somerville, M.D.
 Debra A. Vachon, M.D., FACS, FASCRS
 James J. Zalucki, M.D., FACS, FASCRS
 Robert Akbari, M.D.

Notifier: Colon Rectal Surgical Associates, LLC

Patients Name: _____ ID# _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay. Medicare does not pay for everything even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for (D) _____ below.

(D) _____	(E) Reason Medicare may not pay	(F) Estimated Cost
1. Screening office visit 2. Screening Flexible Sigmoidoscopy 3. Screening Colonoscopy Average Risk 4. Screening Colonoscopy High Risk	1. Medicare does not cover screening visits 2. Medicare only covers screening flex sig once every 4 years. You must wait 10 years following a screening colonoscopy before having a screening flex sigmoidoscopy. 3. Average risk – Medicare covers 1 colonoscopy every 10 years and you must wait 4 years following screening flexible sigmoidoscopy. 4. High risk – Medicare cover 1 colonoscopy every two years and you must wait 4 years following screening flexible sigmoidoscopy.	

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive (D) _____ listed above.

Note: If you choose option 1 or 2 we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) Options: Check only one box. We cannot choose a box for you.

- Option 1.** I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I make to you, less co-pays or deductibles.
- Option 2.** I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- Option 3.** I don't want the (D) _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also receive a copy.

(I) Signature: _____	(J) Date: _____
----------------------	-----------------