

GASTROINTESTINAL SPECIALISTS, P.C.

Gastroenterology, Hepatology and Therapeutic Endoscopy

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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 PHYSICIAN'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 from 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

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
 - Pacemaker
 - Liver Disease
 - Stomach/Bowel Surgery
 - Other _____
 - PCP _____
 - Diabetes
 - Defibrillator (AICD)
 - Kidney Failure
 - Sleep Apnea
 - Asthma
 - Artificial Valve or Endocarditis
 - Congestive Heart Failure
 - Heart Disease/Angina/MI
 - Heart stent within 6 months
 - Emphysema
- Previous colonoscopy date: _____ Performing Doctor: _____ Colon results(i.e polyps), _____
 patients weight _____

Recent Symptoms

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

Allergies: _____

Medications: _____

Coumadin: Y / N **Plavix:** Y / N **Aspirin:** Y / N **CPAP:** Y / N
 L Prescribed for: _____ **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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I, _____ (please print) understand that this is not my first screening colonoscopy and although I am at a higher risk due to my condition (i.e., polyps, colon cancer, colitis) this procedure may not be covered at the 100% screening benefits per my insurance policy. My insurance company may now consider this to be a high-risk surveillance and my deductible and co-insurance may apply.

I understand Gastrointestinal Specialists will bill my insurance for the above-mentioned procedure first and that I will be responsible for any outstanding balance on my account.

Patient or Guardian Signature

Date

If you have any further questions, please contact your insurance company by calling the number located on the back of your insurance card.

If this is your first colonoscopy this form does not apply to you