GASTROINTESTINAL SPECIALISTS, P.C.

Gastroenterology, Hepatology and Therapeutic Endoscopy

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264 W. MAPLE ROAD SUITE 200 TROY, MI 48084-5435 (248) 273-9930 FAX: (248) 273-9931 www.metrodetroitgastro.com

SCREENING COLONOSCOPY

Dear	
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 PHYSICAN'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 form 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	underst	and th	ne billing	protoc	col for	Gastr	ointes	tinal
Specialists and	Gastrointestinal	Endoscopy	Cente	er. If	f I have	furthe	r question	s I will	contact	and	speak	to a
representative.												

Thank you, Gastrointestinal Specialists Scheduling Department -Ext. 3010, Ext. 3036 & Ext. 3034

Gastrointestinal Specialists P.C. Name: ____ Birth date: Age: Marital Status: S M W D Sex: M F Race: please circle: American Indian, Asian, African American, Caucasian, Declined Preferred Language: Ethnicity: Please circle: Hispanic or Latino, not Hispanic or Latino, Unknown, Declined Address: _____ ZIP CODE Home Phone #: (E-Mail Address: _____ Work Phone #: () _____ Employer address: Employer: If you were referred by a Physician please list their name and address below. ADDRESS REFERRING DOCTOR Please list Primary Care Physician below: (If different from above) ADDRESS PRIMARY DOCTOR PRIMARY INSURANCE: Subscriber Name Date of Birth Employer Address Employer Name: Relation to insured: Self Spouse Child Insured's ID Number Group # SECONDARY INSURANCE: Subscriber Name Date of Birth Employer Address Employer Name Relation to Insured Self Spouse Child Insured's ID Number_____ Group #____ OFFICE POLICY REGARDING INSURANCE: Your insurance is a method of reimbursement to you for professional expenses paid to the physician and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charge. You will be responsible for any deductibles, co-payments, or other balances not paid by your insurance, including no call/no show fees without 24 hour notification to cancel/change appointment. IT IS EXPECTED THAT CHARGES FOR OFFICE VISITS WILL BE PAID AT THE CONCLUSION OF EACH OFFICE VISIT. AUTHORIZATION FOR DIRECT BILLING: I hereby assign all medical and/or surgical benefits, including major medical benefits (Medicare, private insurance, and other health insurances) to Gastrointestinal Specialists PC. This assignment will remain in effect until revoked by me in writing. A photocopy is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize assignee to release information in my medical record to third party payers to secure payment for services rendered. DATE SIGNED RESPONSIBLE PARTY______DATE_____

Gastrointestinal Specialis	sts, P.C. 264 W. Maple Ro	ad, Suite 200 Tro	y, MI 48084 Phone	: 248.273.9930	Fax: 248.273.9
PATIENT'S PERSO	NAL HISTORY	Date	Pa	atient Number	
Confidential Record: Infor	mation contained here will r	not be released exc	70 50	authorized us to	do so.
Last Name Fi	rst	Middle	Birth Date	Age	
Address		City/State/ZIP	Home Phone #	# Alt. Phone #	
Emergency Contact		Relationship to Patie	ent		
Family History	Family History Yourself Mot		Father	Siblings	Children
Colon Polyps					
Colon Cancer					
Ulcerative Colitis/Crohn's					
Medical History					
□ Hypertension	□ Diabetes	□ Asthn	na	□ Emphys	ema
na Pacemaker	□ Defibrillator (AICD) 🗆 Artific	cial Valve <i>or</i> Endoc	arditis	
□ Liver Disease	□ Kidney Failure	□ Conge	estive Heart Failur	e	
Stomach/Bowel Surgery	√ □ Sleep Apnea	□ Heart	Disease/Angina/M	I	
Other		_ Heart	stent within 6 mo	nths	
PCP					
Previous colonoscopy date: patients weight	Performing Doc	tor:	Colon resu	lts(i.e polyps), _	
Recent Symptoms	s				
	Stroke/TIA	n Persistent / Ma	oderate to Severe	Shortness of B	reath
Loss of Consciousness/F		a reconstency in	oderate to severe	511011111111111111111111111111111111111	reacti
Allergies:					
Madiantiana					
Medications:					
Coun	nadin: Y / N	Plavix: Y / N	Aspirin: Y	′/N CP	PAP: Y / N
L Pre	scribed for:	Oxygen: Y / N	353		
		1 , 5 ,			
Sedation & Anesthes	sia				
Any problems in the past	?	Y / N	Explain:		
Severe nausea/vomiting a	afterwards?	Y / N			
GI/Bowel Symptom	s				
Rectal Bleeding:	Y / N	Anemia	/Low Iron:	Y / N	
Heme+ Stool cards:	Y / N	Chronic	Heartburn/Reflux:	Y / N	
Diarrhea:	Y / N	Nausea	Nausea / Vomiting: Y / N		
Constipation:	Y / N		Swallowing:	Y / N	
Change in Stools:	Y / N				
Alternating RM'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.

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I,	(please prin	t) understand that this is	s not my first
screening colonoscop	y and although I am at a high	her risk due to my condit	tion (i.e.,
polyps, colon cancer,	colitis) this procedure may n	ot be covered at the 100°	% screening
benefits per my insur	ance policy. My insurance co	ompany may now consid	er this to be a
high-risk surveillance	and my deductible and co-in	nsurance may apply.	
	ntestinal Specialists will bill n		
procedure first and th	nat I will be responsible for a	ny outstanding balance o	on my account.
Patient or Guardian Signature		Da	nte
If you have any furth	er questions, please contact y	your insurance company	by calling the
number located on th	ne back of your insurance car	d.	

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