

## Completing the Colonoscopy Forms

***Please read and follow these instructions carefully before submitting your paperwork.***

**Complete the attached 6 pages according to the instructions below.**

**Form 1, Patient Information Form**

Please fill out form completely.

**Form 2, History and Physical (2 pages)**

***Page 1***

Please fill out each section of the form. If a section does not apply, please note "None."

***Page 2***

At the top of the form, please indicate your reason for the colonoscopy.

Under Present Medical History, please check each question either yes or no. Blank boxes may cause a delay in scheduling.

Sign and date the bottom of the form.

**Form 3, HIPAA Acknowledgement Form/Insurance Assignment**

At the top of the form, record your name in the blank.

Sign and Date all three Signature boxes. If you are not a Medicare or Medicaid beneficiary, you do not need to sign the last line assigning benefits.

**Form 4, Colonoscopy Notification Statement**

Read and sign on Patient Signature line.

**Form 5, Medicare Advanced Beneficiary Notice (ABN)**

ONLY if you are a Medicare beneficiary, read and sign this form; otherwise, disregard it.

**Insurance**

Make an enlarged, legible (clear) copy of all your insurance card(s).

Obtain specialist referral if applicable. If your insurance plan requires a referral to a specialist, please contact your primary care physician to obtain one. If you are unsure if your plan requires one, please call the customer service number on your insurance card.

**Submit all forms with the copy of your insurance card** by mail or fax to the appropriate office. Office location information is posted on our website at [www.atlantacol.com](http://www.atlantacol.com).

**Atlanta Colon and Rectal Surgery, PA**

Today's Date: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Apt \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Marital Status: (check one)  Single  Married  Widowed  Divorced

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Patient Contact Information:**

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Please indicate the best number and time of the day to reach you:

\_\_\_\_\_

**Medical Contact**

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

**Scheduling Request:** Please indicate any scheduling preferences (e.g. day, date, time) below. If you are providing specific dates, please provide at least three choices in order of preference. Our schedulers will make every effort to accommodate your request; however, coordinating patient, physician, and facility schedules is a complex process.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



ATLANTA COLON & RECTAL SURGERY, P.A.

Today's date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status: Single Married Widowed Divorced

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Current Medications & Dosage

(If you do not know the drug name, list the condition)

\_\_\_\_\_

\_\_\_\_\_

Please list all your DRUG ALLERGIES: \_\_\_\_\_

Social History

Do you smoke? \_\_\_\_\_

Frequency \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_

Frequency \_\_\_\_\_

Do you take drugs? \_\_\_\_\_

Frequency \_\_\_\_\_

Past Medical History

Have you ever experienced any of the following conditions? (Please check all that apply.)

- Anemia
- Asthma
- Bladder Infection
- DVT
- Pulmonary Embolism
- Cancer
- Colitis
- Crohn's Disease
- Diabetes
- Heart Disease
- Hepatitis
- High/Low Blood Pressure
- HIV +
- Kidney Disease
- Mitral Valve Prolapse
- Pneumonia
- Stroke
- Thyroid Disease
- Urinary / Prostate
- Other History:

Past Surgical History

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a colonoscopy? Yes No

If yes, when \_\_\_\_\_ and results \_\_\_\_\_

Family Medical History

	Relative	Condition & Age	None
Family History of Cancer			
Family History of Colon Polyps/Tumors			
Family History of Colon Disease			

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Present Medical Complaints**

Reason for your visit: \_\_\_\_\_

Indicate your response of either yes or no to each item below. Please do not leave items blank. Any mark other than X will be considered a response and not a deferment.

**Review of Systems**

	No	Yes		No	Yes		No	Yes
<b>Constitutional</b>			<b>Cardiovascular</b>			<b>Neurological</b>		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath w/walking	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Light headed/dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion or seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Chronic coughing	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>		
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>			<b>Ear/Nose/Mouth/Throat</b>		
Rectal Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Protrusion from rectum	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness/swelling	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Walking	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<b>Integumentary (skin/breast)</b>			Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary</b>			Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic/Lymphatic</b>		
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>
Burning/Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence of urine	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes</b>			HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	Hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Eye disease/injury	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Male-Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>				Hyper/Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Female-vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Female-# of pregnancies _____								
Female-Stool through vagina	<input type="checkbox"/>	<input type="checkbox"/>						

How often do you move your bowels? \_\_\_\_\_ per day \_\_\_\_\_ per week

**Patient Statement: To the best of my knowledge, the above information is accurate and complete.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Statement: I have reviewed the questionnaire with the patient.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**ATLANTA COLON AND RECTAL SURGERY, P.A.**  
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received a copy of ATLANTA COLON AND RECTAL SURGERY, PA's Notice of Privacy Practices.

I consent to the use and disclosure of my protected health information by Atlanta Colon and Rectal Surgery, PA for the purpose of providing treatment to me, obtaining payment for my health care bills, and/or to conduct health care operations.

I understand I have a right to review Atlanta Colon and Rectal Surgery, PA's Notice of Privacy Practices prior to signing this document. Atlanta Colon and Rectal Surgery, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the practice website, calling the office and/or requesting a revised copy by sent in the mail.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Atlanta Colon and Rectal Surgery, PA is not required to agree to the restrictions that I may request. However, if Atlanta Colon and Rectal Surgery, PA agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Atlanta Colon and Rectal Surgery, PA has taken action in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

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**ASSIGNMENT OF BENEFITS**

**Assignment of Insurance Benefits:** I hereby authorize payment directly to Atlanta Colon and Rectal Surgery, PA, of any and all insurance benefits for this visit, hospital inpatient and outpatient stay, otherwise payable to or on behalf of the patient or to me, and authorize release of information requested by the patient's insurance company (ies).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or authorized representative)

**Assignment of Medicare and/or Medicaid Benefits:** I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or Georgia Medical Care Foundation or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or authorized representative)

**Office Use Only:**  
**Refusal to Sign:**

1. _____	_____
Employee Signature	Date
2. _____	_____
Employee Signature	Date

## Colonoscopy Notification Statement

You may be receiving bills from separate entities associated with your procedure, i.e. physician, facility, anesthesia, and/or laboratory charge. Atlanta Colon and Rectal Surgery, PA can only provide you with information associated with our fees.

**Be informed: Call your insurance company and verify benefits and coverage.**

- 1. Are the procedure and/or diagnosis covered under your policy?**
- 2. Is my diagnosis code(s) considered screening or medically necessary?**  
*This will affect your financial responsibility.*
- 3. What is my (patient) responsibility going to be? Deductible, Coinsurance, etc.**  
Ask them to explain your benefits for both a screening and medically necessary (diagnostic) colonoscopy. *A finding on a colonoscopy may change a screening to a medically necessary with some insurance carriers (see below).*

Procedure (CPT): Please contact  
Scheduler.

Diagnosis (ICD9): Please contact  
Scheduler.

### **Beware:**

Due to the nature of our specialty, procedures may often become more complex than originally determined. Therefore, your CPT code may be changed following your procedure. National Correct Coding Guidelines require that physicians bill the codes associated with the actual procedures performed (postoperative), not the planned procedure (preoperative). **This means your “screening” colonoscopy may be changed to a “medical necessary” colonoscopy.**

Insurance is very frustrating and we appreciate your patience and understanding.

*If your insurance plan has a high deductible, you may be asked to make a deposit prior to your procedure. For our fees, deposits, or an explanation of this form, please call our billing department at 404-252-8445.*

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Patient Signature

Notifier: Atlanta Colon and Rectal Surgery, PA  
5667 Peachtree Dunwoody Rd., Suite 330, Atlanta, GA 30342  
Phone: 404-252-5669

Patient Name:

Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for procedure 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 the procedure below.

Procedure	Reason Medicare May Not Pay:	Estimated Cost:
Colonoscopy	You may have had previous screenings that disqualify you under the Medicare Colonoscopy Screening Guidelines.  Medicare allows for one colonoscopy screening every 10 years for non high risk patients and once every 24 months for high risk patients.	\$208.43

#### 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 the procedure 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.

#### OPTIONS:

**Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the procedure 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 made to you, less co-pays or deductibles.

**OPTION 2.** I want the procedure 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 procedure listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

#### 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 also receive a copy.

Signature:

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.