<u>Colonoscopy Evaluation</u>

Today's Date: ________

Patient: _______________________ **Account: ____________**

Please choose one of the following reasons for your visit:

☐ Diagnostic/therapeutic colonoscopy
I **<u>have a symptom(s)</u>** and/or diagnosis and need to discuss undergoing a colonoscopy.

☐ Preventive Colonoscopy Screening
I **<u>do not</u>** have any **<u>symptoms.</u>**
I **<u>do not</u>** have any personal or family **<u>history</u>** of colon cancer, polyps, gastrointestinal disease, etc

☐ High Risk Screening
I **<u>do not</u>** have any **<u>symptoms.</u>**
I **<u>have a personal or family history</u>** of colon cancer, polyps, gastrointestinal disease, etc

Disclaimer: *The preventive services portion of The Patient Protection and Affordable Act only applies to your colorectal screening service. An evaluation and treatment of any sign, symptom, and/or colorectal disease will be processed under your regular insurance benefits; therefore, out of pocket expenses may apply. Please contact your insurance carrier with any questions or concerns regarding your insurance coverage.*

________________________________	____________
Patient Signature	Date