

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.

Form 6, Colonoscopy Screening Acknowledgement

This form is only for patients scheduling a colonoscopy screening and who are not experiencing any colorectal symptoms.

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.

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)

Blank lines for listing current medications and dosages.

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.)

- Checkboxes for various medical conditions: 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

Blank lines for listing past surgical history.

Have you ever had a colonoscopy? Yes No

If yes, when _____ and results _____

Family Medical History

Table with 4 columns: Relative, Condition & Age, None. Rows include Family History of Cancer, Polyyps/Tumors, and Colon Disease.

Patient Name: _____

Date of Birth: _____

Present Medical Complaints

Reason for your visit:

Please indicate either a yes or no response next to each item. Please do not leave blanks. For physician review purposes, any type of mark (e.g. line, X, check, etc.) will indicate a negative or positive response and not a deferment.

<u>Review of Systems</u>	No	Yes		No	Yes		No	Yes
Constitutional			Cardiovascular			Neurological		
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"/>
Gastrointestinal			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"/>	Respiratory			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"/>	Psychiatric		
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"/>	Musculoskeletal			Ear/Nose/Mouth/Throat		
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"/>	Integumentary (skin/breast)			Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary			Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic		
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"/>	Eyes			HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
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

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
Know what you will owe!

Colonoscopy CPT: Please contact the scheduler for this information.

- Diagnostic/therapeutic colonoscopy; Diagnosis:** _____
Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.
- Surveillance/ High Risk Screening Colonoscopy; Diagnosis:** _____
Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).
- Preventive Colonoscopy Screening; Diagnosis:** _____
Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Who will bill me? You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. Atlanta Colon and Rectal Surgery, PA can only provide you with information associated with our fees.

How will I know what I will owe?

Call your insurance carrier and verify the benefits and coverage by asking the following questions. Codes for your procedure are listed above. (You will need to give the insurance representative your preoperative CPT and Diagnosis codes.)

1. Is the procedure and diagnosis covered under my policy? Yes No
2. Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).

Diagnostic/Medical Necessary Benefits

Deductible: _____ Coinsurance Responsibility: _____

Facility in Network: Yes No

Preventative/Wellness/Routine Colonoscopy Benefits:

Are there age and/or frequency limits for my colonoscopy? (e.g. one every ten years over the age of 50, one every two years for a personal history of polyps beginning at age 45, etc)

No Yes if so; _____

Deductible: _____ Coinsurance Responsibility: _____

3. If the physician removes a polyp, will this change your out of pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit: more out of pocket expenses. Carriers vary on this policy.) No Yes

Representative's Name: _____ Call Reference #: _____ Date: _____

Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening? No. The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

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. Further information on Colonoscopy can be obtained on our website at www.atlantacol.com.

Patient Signature

Date

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.	\$219.85

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: _____
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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.

Colonoscopy Evaluation

Today's Date: _____

Patient: _____ Account: _____

Please choose one of the following reasons for your visit:

- Diagnostic/therapeutic colonoscopy
I **have a symptom(s)** and/or diagnosis and need to discuss undergoing a colonoscopy.
- Preventive Colonoscopy Screening
I **do not** have any **symptoms**.
I **do not** have any personal or family **history** of colon cancer, polyps, gastrointestinal disease, etc
- High Risk Screening
I **do not** have any **symptoms**.
I **have a personal or family history** 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

Colonoscopy: What you need to know!

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are many caveats that prevent patients from taking advantage of this provision. One example is a “grandfather” clause; where insurance companies have two years before offering preventative services at no cost. There are now strict and changing guidelines on which colonoscopies are defined as a preventative service (screening). These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost. Patients may be required to pay co-pays and deductibles.

Our practice has created this document to sort through some of the confusion and misinformation out there. Here is what you need to know:

Colonoscopy Categories:

Diagnostic/therapeutic colonoscopy

Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.

Surveillance/ High Risk Screening Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventive Colonoscopy Screening

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Your primary care physician may refer you for a “screening” colonoscopy; however, you may not qualify for the “screening” category. This is determined in the pre-operative process. *Before the procedure, you should know your colonoscopy category.* After establishing what type of procedure you are having, you can do some research.

Who will bill me?

You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. Atlanta Colon and Rectal Surgery, PA can only provide you with information associated with our fees.

How will I know what I will owe?

Reference the information on the **Colonoscopy Notification Statement** included in this packet. Call the ACRS billing department at 404-252-8445 with any questions or concerns. They are a great source of information and are happy to help if you are struggling to understand your financial obligations. However, it is still necessary for you to first call your insurance company and ask the above questions.

Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening?

No. The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

Patients need to understand that strict government and insurance company documentation and coding guidelines prevent a physician from altering a chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law.

However, if a patient notices an error in the medical record (e.g. date of birth, medication dosage, history notation, etc), he/she may request a correction/amendment by completing the "Request for Correction/Amendment of Protected Health Information" form and forwarding it to the physician's medical assistant. This form can be obtained on our website at www.atlantacoln.com.

What if my insurance company tells me that ACRS can change, add, or delete a CPT or diagnosis code?

This is actually a common occurrence. Often member service representatives will tell a patient that if only the physician coded it with a "screening" diagnosis it would have been covered at 100%. However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient. Remember, many insurance carriers only consider a patient over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as a "screening" (V76.51).

If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department who will perform an audit of the billing and investigate the information given. Often the outcome results in the insurance company calling the patient back and explaining that the member services representative should never suggest a physician change their billing to produce better benefit coverage.