



Procedure Financial Disclosure

You have been scheduled for a colonoscopy: CPT Code: _____ and/or an Upper Endoscopy (EGD):CPT: 43235 on _____ at

- Pikes Peak Endoscopy Center
- Briargate Endoscopy Center
- MemorialMain
- Memorial North

The indicating diagnosis for this procedure is _____. The diagnosis code(s) submitted on the claim for the procedure will indicate the actual findings of the procedure. (i.e., what may have been scheduled as a screening, could change to diagnostic due to the findings during the procedure.)

If you are having your procedure performed at Pikes Peak Endoscopy Center or Briargate Endoscopy Center, we are Medicare certified free-standing ambulatory surgical centers owned by the physicians of Gastroenterology Associates of Colorado Springs (GACS). **GACS physicians do not perform "office based" endoscopy services. Therefore, office visit co-pays will not apply for these services.**

Endoscopy services are surgical procedures and will be processed under the surgical provisions of your insurance plan. Some insurance plans have exclusions for out-patient surgical procedures or have different out-of-pocket expenses based on the location where the procedure is performed. Individual and Family deductibles may apply. While the procedures are diagnostic in nature, they are not considered a diagnostic test by the insurance carrier, nor the American Medical Association.

Our Pre-Cert Specialist will contact your insurance plan to see if pre-certification is required for the procedure. Please note that pre-certification is not a guarantee of payment as per your insurance company.

As a courtesy to our patients, we will attempt to find out what your benefits will be, however, all insurance companies specify that the information they provide to us does not guarantee payment or that the amounts they quote us due by the patient will be the same after the claim is processed. You are responsible for additional deductibles, co-pays or any co-insurance your insurance company may assess to your responsibility. Services not covered or deemed not medically necessary by your plan will be your responsibility. **We strongly encourage you to call your insurance carrier to understand what your benefits are for the procedure that has been scheduled.** We do have a cancellation policy and fee associated with the cancellation of procedures if we are not notified within the specified time period. It is your responsibility to understand what your coverage is and if you have questions regarding your coverage, you should contact your insurance company. You will need to provide them the information listed in the first section above. Be sure to have them review the "indicating" diagnosis as some plans have limited coverage based on diagnosis, or difference in coverage for screening vs. diagnostic procedures.

If you have not already done so, you will need to provide us with your correct insurance information at least 14 days prior to your scheduled procedure to allow time for pre-certification. You need to be sure we have your primary, secondary (and tertiary) insurance information as all may require pre-certification. Call (719) 632-7101, and follow the prompt for the appropriate physician that will be performing your procedure to report updated insurance information. Failure to report the correct updated insurance information prior to the procedure may result in you being responsible for the full balance due. If you present a different insurance at the time of check in for your procedure, your procedure may be rescheduled to a future date that allows us to complete the pre-certification process.

The procedure for which you are scheduled generates the following fees and will be billed separately: (1) a professional fee for the physician's services, (2) a facility fee for use of the surgery facility, and (3) if a tissue biopsy is required, a fee for pathology services from the pathologist/lab.

- Please bring this signed form with you on the day of your procedure**
- Please mail this form back to our office (address below) 4-5 days prior to your procedure**

Gastroenterology Associates of Colorado Springs, L.L. P./Pikes Peak Endoscopy and Surgery Center L.L.C./Briargate Endoscopy Center, L.L.C.

Acknowledgement of Receipt of Procedure Financial Disclosure

I have received a copy of the Procedure Financial Disclosure for Gastroenterology Associates of Colorado Springs, LLP.

Patient Signature

Date

Print Name

FINANCIAL POLICY AND PATIENT AGREEMENT

IMPORTANT – PLEASE READ

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Gastroenterology Associates of Colorado Springs, LLP, Pikes Peak Endoscopy & Surgery Center, LLC and Briargate Endoscopy Center, LLC. Please be advised that Pikes Peak Endoscopy & Surgery Center and Briargate Endoscopy Center are owned and operated by the physicians of Gastroenterology Associates of Colorado Springs, LLP and are fully certified Medicare approved and licensed by the state of Colorado.

APPOINTMENTS: Please arrive at least 30 minutes prior to your appointment to give yourself time to update your records or complete paperwork required by your insurance.

CANCELLATION POLICY: In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment so that we can accommodate another patient's needs. If you fail to cancel or reschedule in the appropriate amount of time the below fees will be applied to your account

- Office visits **MUST** be cancelled/rescheduled no later than **24 hours prior to your appointment; a \$25.00 charge will be assessed if this does not occur.**
- Procedures (Colonoscopy/EGD) **MUST** be cancelled/rescheduled no later than **48 hours prior to your scheduled procedure; a \$75.00 charge will be assessed if this does not occur.**

UNINSURED PATIENTS: Payment for services is **due in full** at the time of service or payment arrangements need to be made with our billing department **prior** to the service. For your convenience, we accept VISA, MasterCard, cash, checks and money orders.

INSURED PATIENTS: As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s). Please be aware that although we participate with most insurance companies, **it is your responsibility to make sure we are a participating provider with your plan.** If we have an agreement with your insurance carrier, we will receive direct payment for covered services. **Co-payments are due at the time of service.** Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. **You will be responsible for any remaining balance on your account once your insurance has processed our claim.**

Since your insurance policy is an agreement between you and the insurance carrier, we will not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care.

REFERRALS: If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and it is your responsibility to obtain one. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. If you are having a procedure performed at Pikes Peak Endoscopy & Surgery Center or Briargate Endoscopy Center and a pre-certification for that procedure is required, we will obtain authorization for that procedure on your behalf. If your insurance company does not authorize the procedure, you will be notified of your financial responsibility prior to the procedure being performed.

COPIES OF MEDICAL RECORDS: We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. We do not charge patients for copies of their own records. Fees for copying records requested from businesses are as follows: \$14.00 for 10 or fewer pages, 50 cents per page for pages 11-40 and 33 cents per page after 40 pages.

ADDITIONAL CHARGES:

Missed Clinic Appointments	\$25.00
Missed Procedure Appointments	\$75.00
Returned Checks	\$25.00

OVERPAYMENTS: We will not refund credit balances less than \$10.00.

LATE PAYMENTS: Accounts 30 days or more past due will begin accruing finance charges.

COLLECTION AGENCY: We refer all unpaid accounts over 90 days past due to a third party collection agency unless the account has been approved for payment arrangements.

CUSTOMER SERVICE: If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (719) 477-0755. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a \$25.00 service charge on all returned checks.

I acknowledge full financial responsibility for services provided to me. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and coinsurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center, and/or Briargate Endoscopy Center.

Patient Signature

Witness Signature

Date



ERCP INSTRUCTIONS

ONE WEEK BEFORE THE PROCEDURE:

- Discontinue iron supplements and aspirin, Aleve, Motrin, Advil, or any other anti-inflammatory medications. You may take Tylenol and/or a multivitamin with iron.
- You **must** speak with your primary care physician or a specialist before your scheduled colonoscopy if you are taking **Coumadin, Plavix, Ticlid, or any other Blood Thinners**. You may need to stop these medications a week prior to your procedure.
- It is important to continue to take all other prescribed medications. On the day of the procedure, you may take your prescribed medications with a small sip of water up to two hours before your procedure.

YOUR ERCP IS SCHEDULED FOR _____ AT _____ am/pm.

REPORT TO THE MEMORIAL OUTPATIENT AREA AT _____ am/pm.

THE DAY BEFORE THE EXAM YOU MAY EAT A NORMAL DIET AND TAKE YOUR MEDICATIONS.

DO NOT EAT OR DRINK AFTER _____ ON _____.

ON THE DAY OF THE EXAM YOU MAY TAKE YOUR MEDICATIONS 2 HOURS BEFORE YOU ARRIVE FOR YOUR PROCEDURE. YOU MAY BE GIVEN ANTIBIOTICS AND/OR HAVE YOUR BLOOD DRAWN WHEN YOU ARRIVE FOR YOUR PROCEDURE.

YOU WILL BE IN THE RECOVERY ROOM FOLLOWING THE PROCEDURE UNTIL THE EFFECTS OF THE SEDATION WEAR OFF.

IF YOU HAVE ANY QUESTIONS PLEASE CALL 632-7101 AND SPEAK TO THE APPROPRIATE SCHEDULER.

INFORMED CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

Name: _____

1. Condition: Dr. _____ has explained to me that the following condition(s) exist in my case: _____

2. Proposed Procedure(s): I understand that the procedure(s) proposed for evaluating and treating my condition is/are: Esophagogastroduodenoscopy-Examination of the lining of the esophagus, stomach and duodenum with a flexible video endoscope, and if necessary remove polyps and or small pieces of tissue (biopsies) for diagnosis, control bleeding, and/or dilatation of strictures.

I have had the likelihood of achieving a successful outcome explained to me by my physician as _____

3. Risks/Benefits of Proposed Procedure(s):

- A. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.
B. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to: Perforation, bleeding, drug reaction, broken/dislodged teeth.

4. Anesthesia:

- A. The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.
Sedation:
B. Medication(s) may be given through an intravenous catheter (IV) and/or by mouth to relax you and to minimize any discomfort that you might experience. You will feel drowsy and may even sleep through much of the procedure, but will be easily awakened when spoken to or touched. You may or may not remember the procedure. Your physician, who has been trained in the administration of sedation, will give or direct a registered nurse to administer your medications. During your procedure your blood pressure, heart rate, breathing and oxygen level in your blood will be monitored. Occasional side effects may include headache, drowsiness, nausea, vomiting, allergic reaction, unpleasant memories of the experience, or other adverse reactions. Risks include: failure of adequate sedation resulting in termination of procedure and possible loss of cardiac and/or respiratory function requiring intervention. You will be monitored by a registered nurse until the effects of the medication wear off. You will not be allowed to drive yourself, so arrangements must be made for a responsible adult to provide you with transportation. You will be given discharge instructions specific to the sedation that you received as well as the procedure.

5. Complications; Unforeseen Conditions; Results: I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

6. Acknowledgments: The available ALTERNATIVES, some of which include Upper GI Surgery, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

7. Observation: I understand observation of surgical procedures is limited to members of the healthcare team and designated sales representatives in a formalized healthcare program. I authorize the presence of medical observers approved by my physician during my procedure.

8. Medical Photography/Videotaping: I understand that photographing/videotaping, restricted to members of the healthcare staff, is at time necessary as determined by my attending physician, including appropriate portions of my body for medical, scientific, or educational purposes provided my identity is not revealed in any way. Yes _____ No _____

9. Healthcare Students: I understand that there may be times that, under the direct supervision of my physician, a healthcare student may observe or participate in my procedure. I understand that I have the right to refuse to have a healthcare student participate in the procedure. I do _____ do not _____ authorize medical student(s) to participate in the procedure(s) set forth above.

10. Consent to Procedure(s) and Treatment: Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

Patient (or person authorized to sign for patient) _____ Date _____

Witness Date _____ Date _____

Physician Declaration: I have explained the contents of this document to the patient and have answered all the patient's questions, to the best of my knowledge. I feel the patient has been adequately informed and has consented. I feel the patient has been adequately informed and has consented.

Physician _____ Date _____ Time _____

SEDATION / MODERATE

Patient's Name _____ Physician _____ Date _____

Instructions: **Must** complete section A, D and E. Complete B & C if H+P not done.

A: H+P completed within 30 days and present on chart. Has there been any change in patient's health status?
 No Yes, explain _____
 If no H+P on chart from today, complete sections B and C
 Reviewed Health Questionnaire (For Outpatient GI, Endoscopy, & Radiology only)
Indications: _____

B: Medical History	No	Yes	Explain	Medication Name	Dose	Frequency	Comments
Hypertension							
Heart Disease							
Lung Disease							
Neuro Disease							
Diabetes							
Renal Disease							
Bleeding Disorder							
ETOH/Substance Abuse							
Anes./Sed. Complications							
Hx stridor, apnea, snoring							
Pain control problems							
Other				Allergies: NKA or update composite list Pregnancy/LMP			

C: Patient Physical Exam
Vital Signs: (BP, HR, RR, baseline SpO2) Weight
See Nurses Notes

General	<input type="checkbox"/> No acute distress <input type="checkbox"/> Well developed, well nourished
Pulmonary	<input type="checkbox"/> Clear bilaterally
Cardiac	<input type="checkbox"/> Regular rate + rhythm <input type="checkbox"/> Able to lie flat
Abdomen	<input type="checkbox"/> Soft <input type="checkbox"/> BS+ <input type="checkbox"/> Non-tender
Neuro	<input type="checkbox"/> A&O to time, place person (age appropriate)
Airway	<input type="checkbox"/> Opens mouth normally <input type="checkbox"/> Neck - normal mobility without pain
Other	

D: Anesthesia Classification
 Check Anesthesia Classification below:
 ~~Anesthesia Consultation~~ Yes No

- Class 1.** Normal healthy patient.
- Class 2.** Mild systemic disease, which does not limit activity (Examples: well-controlled HTN; well-controlled asthma; well-controlled diabetes mellitus)
- Class 3.** Moderate or severe systemic disease, which does limit activity (Examples: poorly-controlled diabetes mellitus; symptomatic respiratory disease [e.g. asthma, COPD]; morbid obesity, stable angina, Obstructive Sleep Apnea (OSA))
- Class 4.** Severe systemic disease that is a constant potential threat to life (Examples: debilitating respiratory disease; end stage renal disease, CHF)
- Class 5.** Moribund patient who is not expected to survive without the procedure

E: NPO Time/Date

Last Food _____
 Last Fluid _____

NPO GUIDELINES:
 -Clear Liquids - 2 hours
 -Breast Milk - 4 hours
 -Formula - 6 hours
 -Solids - 8 hours
 (colonoscopy per prep instructions)

Procedure: _____

Verified by MD / DO: Yes No
 Marking by MD / DO: Yes N/A
 Time Out at _____ hrs

Initials of all present: _____

THE PATIENT HAS BEEN RE-EVALUATED AND IS STILL A CANDIDATE FOR THE PLANNED SEDATION

Date: _____ Time: _____ B/P: _____ Pulse: _____ Airway (patent) _____ MD/DO initials: _____

Physician Signature _____ Date: _____



1400 EAST BOULDER STREET
 COLORADO SPRINGS, CO 80909
 Sedation Procedure - Physician H & P

ADULT HEALTH QUESTIONNAIRE (PRE-SURGERY / PRE-PROCEDURE)

Name (please print) _____ Surgery / Procedure _____

Current Weight _____ Height _____

To be completed on Day of Surgery:

Last Solid Food: _____ Last Fluids _____
(Date/Time) (Date/Time)

Check Yes or No for each item:

	Yes	No	Comments:		Yes	No	Comments:
Heart Disease: Managing Doctor:				Loud Snoring			
Heart murmur				Sleep Apnea / CPAP			
Chest pain with exercise				Daytime Sleepiness?			
Heart Attack				Stop breathing during sleep?			
High Blood Pressure				Awakened by choking/gasping?			
Do you get short of breath walking 2 flights of stairs?				Have you been seen by a Dr. for a sleep disorder?			
Echo/Stress Test in past year							
EKG in past year?				MRSA/VRE			
Lung Disease: Managing Doctor:				Allergies/ Medications			Reaction
Cold / flu last 2 weeks?							
Emphysema / COPD							
Asthma							
Oxygen Use (flow-route)							
Chest x-ray in past year							
Diabetes: Managing Doctor:				Foods: Egg / Soy			
Age Diagnosed?				Latex / Tape			
Blood glucose monitoring			Range: _____	Iodine IV dyes			
General				Other:			
Bleeding tendencies				Medications: Prescription & all Non Prescriptive (i.e., vitamins, herbals)			
Blood Clots / Phlebitis				COMPLETE A LIST OF YOUR MEDICATIONS ON THE BACK OF THIS PAGE			
Liver Problems							
Ulcers / Acid Reflux							
Kidney Failure / Problems							
Lupus (SLE)							
Rheumatoid Arthritis							
Polio / Multiple Sclerosis							
Spinal Cord / Head Injury							
Seizure Disorder							
Mental disability							
Other:							
Smoking History				Surgery History			
Current Smoker?				Year	Surgery		Anesthesia Problems?
Year you quit smoking?							
Number of years smoking?							
How many packs per day?							
Social History							
Alcohol – amount?							
Recreational Drugs							
Jaw problems							
Motion sickness							
Other Medical Problems:							
Do you feel safe at home?							
If no, what do you need?							

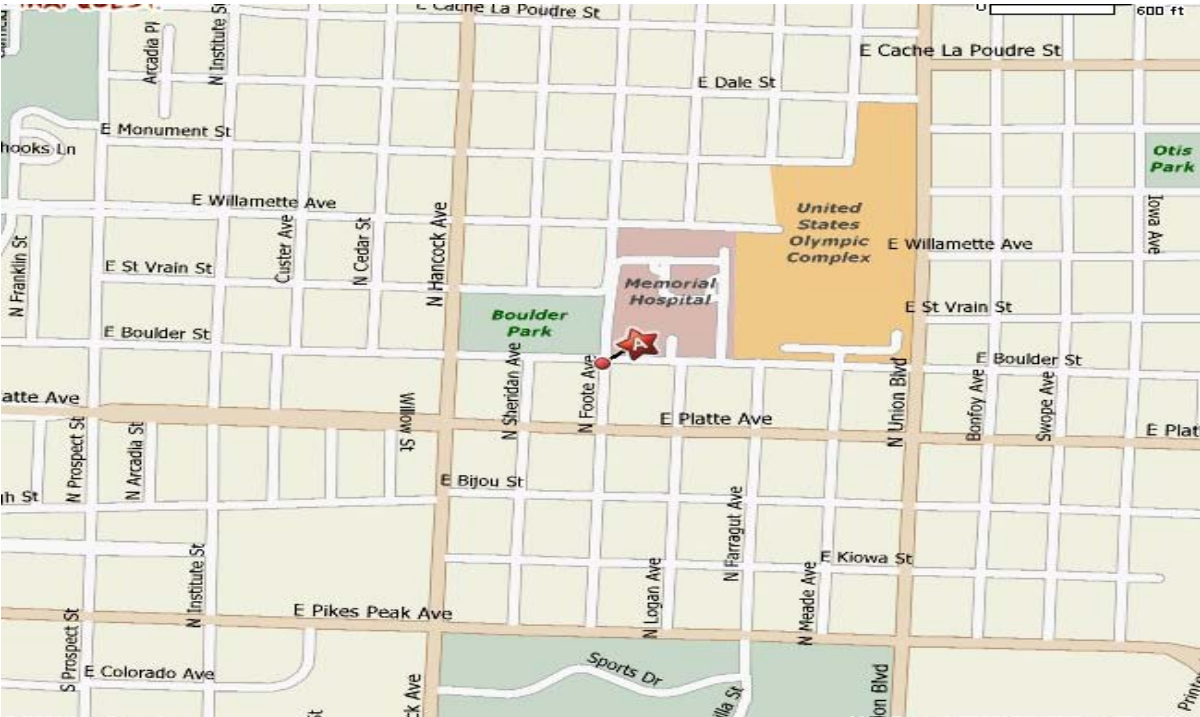
Patient/ Responsible Party (signature) _____ Contact Person / Phone _____
 PSC RN _____ Date _____ Admit Nurse _____ Date _____



Memorial Health System
 1400 East Boulder Street
 Colorado Springs, CO 80909

Adult Health Questionnaire (Pre-Surgery/Pre-Procedure)

MEMORIAL HOSPITAL MAPS



MEMORIAL MAIN 1400 EAST BOULDER STREET



MEMORIAL HOSPITAL NORTH 4050 BRIARGATE PARKWAY