Please bring the following with you to your procedure

- ☐ Current insurance card (s)
- ☐ Photo ID
- ☐ Co-pay if applicable

The following Paperwork needs to be completed prior to procedure and brought with you

- ☐ Patient Information Sheet
- ☐ Authorization for procedure
- ☐ Authorization for anesthesia
- ☐ Acknowledgement of receipt of notice of privacy practices
- ☐ Notice of policy regarding advance directives
- ☐ Procedure financial disclosure
- ☐ Financial policy and patient agreement
- ☐ Online communication consent
- ☐ PPESC health questionnaire
- ☐ Patient medication form – **you must use the sheet attached** – please do not use a separate sheet unless you need additional space.

Financial Disclosure for Endoscopy/Colonoscopy Procedures

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
☐ Memorial Main ☐ 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 approved free-standing ambulatory surgical centers owned by the physicians of Gastroenterology Associates of Colorado Springs (GACS) alone or with others. Subject to certain medical indications, you will have a choice of two anesthesia options for the procedure – IV Conscious Sedation using midazolam (Versed)/Fentanyl or General Anesthesia using propofol. Information about these choices is provided in the Anesthesia Consent Form. If you choose to have General Anesthesia using propofol, anesthesia services will be provided by Anesthesia of the Rocky Mountains which is owned by the physicians at 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-Certification 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 by 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 estimate will be due from 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 before the day of the procedure to understand what your benefits are for the procedure that has been scheduled and your choice of anesthesia.** 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. We do have a cancellation policy and fee associated with the cancellation of procedures if we are not notified within the specified time period. For additional information about cancellation procedures, please see our Financial Policy and Patient Agreement.

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 that will be billed separately: (1) a professional fee for the physician's services, (2) a facility fee for use of the surgery facility, (3) if a tissue biopsy is required, a fee for pathology services from the pathologist/lab and, (4) a professional fee for the anesthesia services if you select General Anesthesia/propofol.

You have a choice of anesthesia services. Please refer to the Anesthesia Consent Form for information about the risks and benefits of these options. You will receive a telephone call regarding your estimated out of pocket costs (after expected insurance payments) for anesthesia. This information will have been provided by your insurance company and, as discussed above, is only an estimate. Your actual financial responsibility may vary depending upon a number of circumstances.

Please bring this signed form with you on the day of your procedure

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Gastroenterology Associates of Colorado Springs, L.L. P./Anesthesia of the Rocky Mountains/Pikes Peak Endoscopy and Surgery Center L.L.C./Briargate Endoscopy Center, L.L.C.
Acknowledgement of Financial Disclosure

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Disclosure for Endoscopy/Colonoscopy Procedures. In addition, by signing below, I represent and warrant that I have authority to enter into this Agreement.I have received a copy of this Financial Disclosure for Endoscopy/Colonoscopy Procedures.

_______________________________________ _______________________
Patient Signature Date

____
Printed Name of Patient

_______________________________________ _______________________
Signature of Patient Representative Date

____
Printed Name/Authority of Representative

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 (GACS), Pikes Peak Endoscopy & Surgery Center, LLC, Briargate Endoscopy Center, LLC, and Anesthesia of the Rocky Mountians, LLC. Please be advised that physicians of Gastroenterology Associates of Colorado Springs, LLP own Pikes Peak Endoscopy & Surgery Center and are co-owners of Briargate Endoscopy Center with Memorial Hospital. Both Centers are fully certified Medicare approved and licensed by the state of Colorado. If you chose to have General Anesthesia using propofol, your anesthesia services will be provided by Anesthesia of the Rocky Mountains which is owned by the physicians at GACS.

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 and a deposit for these amounts will be due at the time of service. 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. Please be aware that pre-authorization by your insurance company does not guarantee insurance payment for services.

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 typically refund credit balances less than $10.00 due to the cost of processing these low amounts. These credits are applied to future due amounts or can be refunded at the request of the patient and picked up at one of our local offices. Refunds that are not claimed or returned to us are reported to the state of Colorado annually.

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, Briargate Endoscopy Center, and/or Anesthesia of the Rocky Mountains.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Policy and Patient Agreement. In addition, by signing below, I represent and warrant that I have authority to enter into this Agreement.

_______________________________________ ____________________
Patient Signature Date

____
Printed Name of Patient

_______________________________________ ____________________
Signature of Patient Representative Date

____
Printed Name/Authority of Representative

_______________________________________ ____________________
Signature of Witness Date

Pikes Peak Endoscopy Center | GACS Gastroenterology Associates of Colorado Springs | Briargate Endoscopy Center

Preparing for your Upper Endoscopy

IF YOU HAVE HAD ANY RESPIRATORY ILLNESSES WITHIN THE PAST 6 WEEKS PLEASE CONTACT OUR OFFICE IMMEDIATELY 719-632-7101, YOU MAY NEED TO BE RESCHEDULED FOR SAFETY REASONS.

One Week Prior to your procedure:

- You **must** speak with your primary care physician or a specialist before your scheduled endoscopy if you are taking **Coumadin, Plavix, Ticlid, or any other blood thinners.** You may need to stop these medications up to a week prior to your procedure. You may continue to take a daily aspirin.

- It is important to continue to take all other prescribed medications. On the day of your procedure, you may take your medications (with water) up until 3 hours before your procedure time. **Please continue to take your Blood Pressure medication, even on the day of your procedure.**

The Day Before your procedure:

- **You may eat a normal diet and take all of your medications.**

The Day Of your procedure:

- **You MUST discontinue eating solid food *8 hours prior to your appointment.* You can drink clear liquids up until 3 hours prior to your appointment time. Do not have anything more by mouth 3 hours prior. If you do consume anything past that point your procedure will have to be canceled or delayed.**

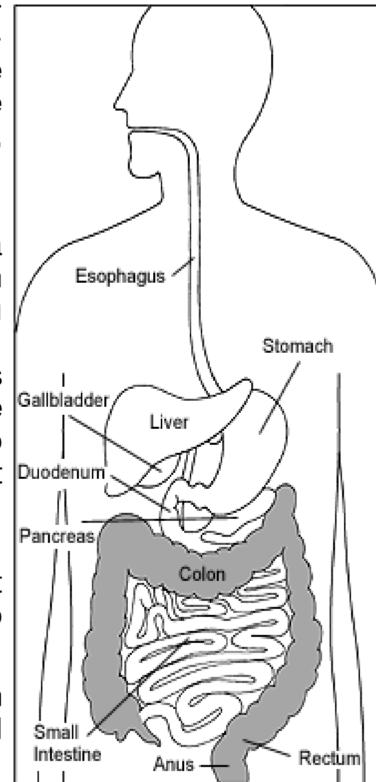
- **You may take your medications with water 3 hours prior to your procedure time.**

If you have any questions, please call a scheduling specialist at

719-632-7101 select option 2.

Once you are done with your procedure, enjoy a gourmet coffee from our

Upper Endoscopy



Upper Endoscopy: Upper Endoscopy is also called EGD - esophagogastroduodenoscopy (eh-SAH-fuh-goh-GAS-troh-doo-AH-duh-NAH-skuh-pee). An Upper Endoscopy enables your physician to look inside the esophagus, stomach, and duodenum (first part of the small intestine). The procedure might be used to discover the reason for swallowing difficulties, nausea, vomiting, reflux, bleeding, indigestion, abdominal pain, or chest pain.

Right before the procedure, your physician will spray your throat with a numbing agent that may help prevent gagging. You will probably be given pain medication and a mild sedative to keep you comfortable and to help you relax during the exam. The procedure entails you swallowing a thin, flexible, lighted tube called an endoscope (EN-doh-skope). The endoscope transmits an image of the inside of the esophagus, stomach, and duodenum, so the physician can carefully examine the lining of these organs. The scope also blows air into your stomach; this expands the folds of tissue and makes it easier for your physician to examine the stomach.

The physician can see abnormalities, like ulcers, through the endoscope that don't show up well on x-rays. Your physician can also insert instruments into the scope to remove samples of tissue (biopsy) for further tests.

Bleeding and puncture of the stomach lining are possible complications of an upper endoscopy. However, such complications are rare. Most people will probably have nothing more than a mild sore throat after the procedure.

The procedure can take up to 30 minutes and possibly longer if there are abnormal growths, inflamed tissue, ulcers, or bleeding. The sedative and pain medicine should keep you from feeling much discomfort during the exam. You will remain in recovery for a period of time until some of the sedative wears off. The sedative can cause you not to retain the discharge instructions provided by the discharge nurse, we recommend you have someone in your room with you to receive those instructions at the time of discharge so they can go over them again with you when you get home.

Preparation: Your stomach and duodenum must be completely empty for the procedure to be thorough and safe, so you will not be able to eat anything for at least 8 hours before your procedure. You have been provided paperwork you should **read <u>4 days</u>** prior to your procedure as there are special directions that may require you to stop certain medications (with your doctor's approval) before your procedure.

You must have someone come with you to stay during your procedure and drive you home afterward—you will not be allowed to drive because of the sedatives and public transportation will not be acceptable.

1699 MEDICAL CENTER PT
COLO. SPGS., CO 80907
(719) 632-7101
Www.GACSonline.com

16699 MEDICAL CTR PT
COLO. SPGS., CO 80907

4110 BRIARGATE PRKWY
SUIT 100
COLO. SPGS., CO 80920

PATIENT INFORMATION SHEET

Patient Name:____SSN#______________

Address:____
STREET CITY STATE ZIPCODE

Date of Birth:______________ **Gender**(please circle): M F **Status:** Married Single Divorced Widowed

Please check the box if you would prefer us **NOT** to contact you at the below numbers/address

☐Home Phone # : ____________________

☐Work Phone # : ____________________

☐Cell Phone # : ____________________ ☐**Email Address**: ______________________________

Emergency Contact (Name/Telephone #):____

Primary Care Physician (First/Last Name):____

Referring Physician (First/Last Name):____

I authorize the physician or anyone acting on his/her behalf to leave pertinent messages for me regarding my medical condition on my answering machine and/or voice mail.

(Please circle one) Yes No

Financially Responsible Party *(If Different From Patient)*

Last Name:__________________________ First Name:_________________________ MI:_____

Street Address:_____________________________________City:________________ State:_____

Home Phone:________________________Work Phone:________________ SS#________________

Date of Birth: Relationship to Patient: Gender: M F

Insurance Information *(Must be completely Filled Out)*

Primary Insurance Co Name:	**Secondary Insurance Co Name:**
Insurance Co Address:	Insurance Co Address:
Patient's Insurance Policy #:	Patient's Insurance Policy #:
Patient's Group #:	Patient's Group #:
Insured's Name:	**Insured's Name:**
Insured's SS#:	**Insured's SS#:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Insured's Employer Name:	Insured's Employer Name:
Insured's Employer Phone #:	Insured's Employer Phone #:
Patient's Relationship to Insured:	Patient's Relationship to Insured:

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I hereby authorize payment directly to the physician/facility for all insurance benefits otherwise payable to me.

Signature:____ Today's Date:________________________

PIKES PEAK ENDOSCOPY CENTER

BRIARGATE ENDOSCOPY CENTER

AUTHORIZATION FOR EGD

At Pikes Peak Endoscopy Center or Briargate Endoscopy Center

1. **PROCEDURE AND ALTERNATIVES**:

I, ________________________________, (patient or guardian) authorize Dr. ________________________________ to perform the procedure: **Esophagogastroduodenoscopy** (EGD) examination of the lining of the esophagus, stomach, and duodenum with a flexible video scope, and if necessary remove polyps and/or small pieces of tissue (biopsies) for diagnosis; and dilation (stretching) of the esophagus if indicated.

I understand the reason for the procedure is:____

Alternatives include: Upper GI X-rays, surgery____

2. **RISKS:** This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: Infection, bleeding, abdominal pain, perforation of esophagus, stomach or duodenum, nerve injury, blood clots, heart attack, allergic reactions, and pneumonia. These risks can be serious and may require surgery or possible be fatal. Estimated perforation rate is 1:2,000, which usually requires surgery.

3. **ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize him to perform such treatment, as he deems necessary.

4. **ANESTHESIA:** I understand that, subject to medical criteria and availability, I may choose to receive anesthesia through either IV Conscious Sedation/midazolam (Versed)/Fentanyl or General Anesthesia/propofol. My physician has discussed these choices with me and additional information is included on the Anesthesia information sheet, which has been provided to me for review. I understand that either IV Conscious Sedation/midazolam/Fentanyl or General Anesthesia/propofol may carry risks, including but not limited to, dental injuries, pneumonia, heart attack, or other adverse reactions including death.

5. **LIMITATIONS OF EGD:** EGD is currently the best test available to examine the esophagus, stomach and duodenum. It does have limitations and may not provide my physician with definitive information about my condition. The test may be limited by technical factors during the examination or by conditions that may develop in the esophagus, stomach or duodenum after the test has been completed (but unrelated to the test). The patient should alert their physician about any change in or new symptoms that may develop. Therefore, I understand that no guarantee or assurance has been made as to the results of the procedure and it may not diagnose, cure or treat my condition.

6. I understand that no guarantee or assurance has been made as to the results for the procedure and that it *may not cure the condition.*

7. **PATIENT'S CONSENT:** I have read and fully understand this consent form, and understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words in this consent form.

I consent to any endoscopic photographing, as determined by my attending physician, for medical purposes.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSCIAN BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

______________________________ ______________________________ ____________________

Signature – Patient/Responsible Party Date Time

____

Signature – Witness

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

____

SIgnature – Physician Date

ANESTHESIA SERVICES

My doctor has explained to me that I will have an endoscopy or colonoscopy procedure. I understand that anesthesia services are typically needed so that my doctor can perform the procedure. This Anesthesia Form explains my anesthesia options and discusses the risks of anesthesia.

I understand that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of anesthesia or the procedure that I am having. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, and blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, or death. I understand that these risks apply to ALL forms of anesthesia and that additional types of anesthesia are described below.

I understand that I have a choice of two methods of anesthesia – Conscious Sedation using midazolam (Versed) and fentanyl or propofol based anesthesia, both administered through an IV.

- Propofol based anesthesia – propofol is an anesthetic agent that has been used for many years for surgery and is often used for endoscopic procedures because of its deeper level of sedation and quick recovery. Advantages of propofol include rapid onset of sedation/sleep, a deeper level of sedation and rapid awakening after the procedure and no associated amnesia. As sedation is predictable, many doctors feel this allows for easier completion of these exams.
    - Propofol is derived from egg-based material and cannot be used in those individuals allergic to eggs or soy.
    - As it provides a deeper level of sedation, a qualified anesthesia provider must administer propofol. As a result, there may be additional costs to the patient associated with propofol administration.

- Conscious Sedation – This is the traditional method of anesthesia using a sedative, midazolam, and a narcotic, fentanyl. As its name implies, its intent is to relax the patient and reduce discomfort. Some people will sleep through the procedure; others will be semi-awake and may recall events during the procedure. The midazolam typically causes amnesia with the patient not able to recall events during the procedure and for some period afterwards, often giving patients the feeling that they were asleep during the procedure. Advantages of conscious sedation include cost savings and a long established history of use in gastroenterology procedures.
    - IV conscious sedation is given under the direction of the gastroenterologist and is included in the facility fee for the procedure. There is no additional charge for IV conscious sedation.

You will have the opportunity to discuss these options with your physician and anesthesia provider prior to your procedure.

Statement of Patient Bill of Rights

BELIEVING IT IS ESSENTIAL THAT PATIENTS ARE RESPECTED AND SUPPORTED

In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of **Pikes Peak Endoscopy Center and Briargate Endoscopy Center**.

Patients have the Right :

To receive services without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor.

To be provided reasonable physical access.

To be provided a secure environment for self and property.

To be provided with appropriate privacy.

To be treated with respect, consideration and dignity.

To expect that all disclosures and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.

To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.

To be given opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.

To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved , and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy. The patient has the right to know the name of the person responsible for the procedures and/or treatment.

To be informed, when appropriate, of treatment policy for an emancipated minor not accompanied by an adult.

To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.

To be informed as to:

- Expected conduct and responsibilities as a patient
- Services available from the facility
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Right to refuse participation in investigational studies or clinical trials
- Methods for expressing grievance and suggestions to the facility
- Disclosure of ownership
- Procedure for reporting public health concerns to the appropriate authorities

To be informed of their rights to change primary or specialty physicians if other qualified physicians are available.

To be free from all forms of abuse or harassment.

To file a grievance against the center by contacting the administrator by mail or phone. If the outcome is not satisfactory a patient can contact the patient may contact the state licensing board through their web site http://www.dora.state.co.us/medical

To exercise his or her rights without being subjected to discrimination or reprisal

PIKES PEAK ENDOSCOPY CENTER

1699 Medical Center Point
Colorado Springs, CO 80907
Phone: (719) 632-7101

www. GACSonline.com

BRIARGATE ENDOSCOPY CENTER

4110 Briargate Prkwy Ste 100
Colorado Springs, CO 80920
Phone: (719) 632-7101

www. GACSonline.com

The Patient Has the Responsibility:

To provide, to the best of the patient's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, existence of advance directives, medications and other information relating to health status.

To follow the treatment plan recommended by the practitioner primarily responsible for the patient's care and other personnel authorized by PPESC or BEC to so instruct the patient.

To accept the consequences of his/her own actions when refusing treatment or not following the practitioners' instructions.

To assure that the financial obligations for health care rendered are fulfilled as promptly as possible.

To follow rules and regulations affecting care and conduct pertaining to the procedures performed.

To be considerate of the rights of other patients and facility personnel and to assist in the control of noise.

To be respectful of the property of other persons and of the facility.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW GASTROENTEROLOGY ASSOCIATES OF COLORADO SPRINGS, PIKES PEAK ENDOSCOPY AND SURGERY CENTER AND BRIARGATE ENDOSCOPY CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center or received by Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may determine that you require the services of a specialist. In referring you to another doctor, Gastroenterology Associates of Colorado Springs/ Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits of health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of service to be provided to you.

For example, Gastroenterology Associates of Colorado Springs Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may use your diagnosis, treatment, and outcome information to measure the quality of the services we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designed in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- **As permitted or required by law**. In certain circumstances, we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- **For public health activities**. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request for that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

  We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees,

or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- **For health oversight activities**. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state or governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable disease.

- **Judicial and Administrative Proceedings**. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- **For activities related to death**. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- **For research**. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- **To avoid a serious threat to health or safety.** We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- **For workers' compensation.** We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Gastroenterology Associates of Colorado Springs and Pikes Peak Endoscopy and Surgery Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center, please contact the Privacy Officer at the following:

Privacy Officer
Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center
1699 Medical Center Point
Colorado Springs, CO 80907
Telephone: (719) 632-7101 Fax: (719) 632-4468

It is the policy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy and Surgery Center and Briargate Endoscopy Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

[1] This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_______________________________ acknowledge that I have received a copy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and/or Briargate Endoscopy Center's Notice of Privacy Practices. This Notice describes how Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and Briargate Endoscopy Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____________________________________ ___________

Signature of Patient or Representative **Date**

____

Relationship to Patient

PIKES PEAK
ENDOSCOPY CENTER

BRIARGATE
ENDOSCOPY CENTER

NOTICE OF POLICY REGARDING ADVANCED DIRECTIVES

Pikes Peak Endoscopy and Surgery Center, LLC and Briargate Endoscopy Center, L.L.C. require the following notice be signed by each patient prior to the scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives. Advance directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are witnessed prior to serious illness or injury.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life threatening situations, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, **this facility (PPESC/BEC) is notifying you it will NOT honor previously signed advanced directives (aka: DNR or Do Not Resuscitate Order) for any patient, however, if you have executed an advance directive in the past you may bring it with you and we will scan it into our system.**

If you have questions, please call (719) 632-7101 and follow the appropriate prompts to speak to a scheduler.

I have read and fully understand the information presented in this release form.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

______________________________ ________________________
Signature – Patient Date

______________________________ ________________________
Signature – Witness to Patient Signature Date

If patient is unable to sign or is a minor, please sign below:

______________________________ ________________________
Signature – Relative or Legal Guardian Date

______________________________ ________________________
Signature – Witness to Relative/Guardian Signature Date

PPESC/BEC HEALTH QUESTIONNAIRE

Patient Name:____ Date:________________________________
Primary Care Physician:_______________________________________ Referring Dr:__________________________
List all physicians you would like a report to go to: ____
Reason for the procedure:____

Please check any symptoms that are of concern:

Change in bowel habits	Weight Loss	Blood in Stools/Rectal Bleeding
Diarrhea	Swallowing difficulty	
Abdominal Pain	Heartburn	

List all allergies/sensitivities to medications, tape, latex, foods, soy, eggs, etc._____________________
None

PLEASE LIST ALL YOUR PREVIOUS SURGERIES

YEAR	SURGERY	COMMENTS

PLEASE ANSWER THE FOLLOWING QUESTIONS

Family history of colon cancer? (whom)___________________
Family history of colon polyps? (whom)___________________
Personal history of cancer? Yes No
Primary site/type:______________________________
Have you had colon polyps before? Yes No
Have you had a positive TB test before? Yes No
Hepatitis B / Hepatitis C / HIV? Yes No
* Do you smoke? Yes No
How many years? _______ How much _________
* Last menstrual Period _________________
* Diabetes ______________ Yes No
* Do you have an implantable heart device?
i.e., defibrillator, pacemaker, etc.? Yes No
* History of heart valve replacement? Yes No
* Do you take blood thinners? Yes No
What kind? _______________________ When did you stop? ___________________
* Do you take aspirin? Yes No
When did you stop?________________________________
* Do you have kidney disease? Yes No
* Do you have sleep apnea or on a CPAP machine/Oxygen Yes No
* Do you have an allergy to Demerol / Versed / Fentanyl? Yes No

Do you have history of any of the following? (circle any that apply) Stroke / Ulcers / Anemia / Heart Attack / High or low blood pressure / Lung Disease (Asthma, COPD, Emphysema)

By signing below, I am agreeing that this information is accurate to the best of my knowledge. I also agree that I will not drive home if I am given any medications during this procedure.

_________________________________ _________________________________ _________________
Patient/Responsible Party Signature Nurse's Signature Date

_________________________________ _________________
Physician Signature **Date**

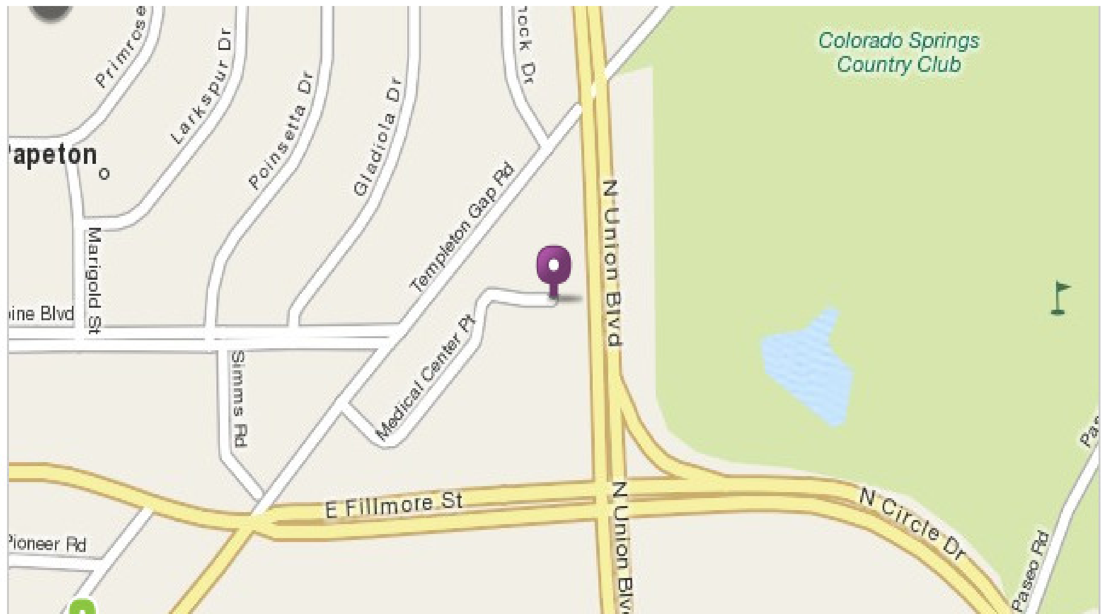
PIKES PEAK ENDOSCOPY CENTER

BRIARGATE ENDOSCOPY CENTER

Pikes Peak Endoscopy Center

1699 Medical Center Point, Colorado Springs, CO 80907

Phone: (719) 632-7101 Fax: (719) 632-4468
www.GACSonline.com



PIKES PEAK ENDOSCOPY CENTER 1699 MEDICAL CENTER POINT

Patient Medication Form

Please list ALL medications you are taking to include any over-the-counter (OTC) medications

Medications	Dose/frequency	Last Taken		Office use only	
				Date to Resume	Hold
			DO NOT FILL OUT BEYOND THIS POINT		

Allergies:____

Reaction:____

Patient Information:
(Apply pt label here)

Follow up Appt ___________
☐ Resume normal diet
☐ Clear Liquids
☐ Other
☐ Resume all pre-procedure medications

Comments/new medication instructions ____

____

Doctor’s Signature _______________________________________ Date ___________

Electronic Communications Informed Consent

For electronic communications with Gastroenterology Associates of Colorado Springs/Pikes Peak Endoscopy/Briargate Endoscopy/Anesthesia of the Rocky Mountains

Electronic (online) communications include e-mail, webmail, secure messaging, electronic file transfer, text messaging and internet "portals" to exchange information between computers, tablets, smartphones. These can be useful ways for patients and healthcare providers to communicate, in addition to more usual visits and phone calls.

Advantages

- E-mail is a simple, convenient and popular way of connecting; many people use it regularly
- Messages can be sent and received without needing both parties online at the same time
- Messages can be saved, copied and forwarded; they keep a record of what was said
- Some messaging systems are encrypted to help keep information private
- Some questions and issues can be handled by online messaging without a phone call or visit

Disadvantages

- E-mail devices and connections can fail, messages can be lost or sent to the wrong person
- There is no way to know if a message was ever received
- Messages can contain typing mistakes
- If the other party is away or their device is turned off, messages might not be seen promptly
- It is possible for a dishonest person to send a false message or impersonate a patient or a doctor
- If both parties are not online at the same time, there is no opportunity to clarify misunderstandings
- Saved copies or messages sent in error can't be erased or retracted
- Messages can contain viruses that can damage systems or steal information
- Some medical questions and issues cannot be handled through online messaging

E-mail Policies

1. **No emergencies or urgent messages.** E-mail is not to be used for emergencies or urgent messages. We do not monitor our In-Box constantly. You can send a message any time, but we may not read it until the next business day. We check messages during regular work hours, and answer them in the order received. We try to deal with messages within 1 work day, but circumstances could cause us to fall behind. Use the telephone if you need a response right away. Of course, in a life-threatening emergency call 911.

2. **Uses.** Our practice accepts E-mail messages for these purposes:

- **General messages** like making or changing appointments, billing issues, or other questions that can be answered by any appropriate staff person.
- **Medical questions.** Our providers may give their professional E-mail addresses to you for medical questions. Although they might sometimes reply after hours, you should not expect providers to

monitoring their mail continuously. Even on call, it's likely the provider is not sitting at a computer. Again, if you have a problem that needs attention right away, use the telephone.

- **Prescription renewals.** You can request refills of medicines we have previously prescribed, the same way as leaving a phone message. If we have a question for you, we may respond by E-mail or phone.

3. **Part of the record.** E-mail messages are considered part of your medical record. Our policies for record privacy and appropriate uses of medical information apply to messages we send to each other.
4. **Security.** You need to protect the E-mail address you give us, to make sure our communications remain private. This is the only way we can trust that messages from your E-mail are really from you, and messages we send are not going to someone else. If we aren't sure about a message, we will try to contact you in some other way.
5. **Availability.** If you ask us to use E-mail to communicate with you, we will assume that you check your In-Box at reasonable intervals. We don't guarantee that we will respond to your messages and we understand you can't guarantee that you will respond to ours. In cases of uncertainty, we will try other ways of communicating.
6. **Sensitive medical information.** We can't always know what information you consider especially private. We take care with all medical records, but we know that some facts are more sensitive than others. Because E-mail can't be guaranteed 100% secure, please don't put extremely sensitive matters in messages without considering this.
7. **Voluntary.** Using E-mail is voluntary for both of us. If we feel you are using E-mail inappropriately (or, if we think your address has been hacked by an imposter), we may block your messages. If you decide you don't want to receive E-mail from us any longer, just let us know.
8. **Changes of address.** If your E-mail address changes, you need to let us know.
9. **Non-essential uses.** We will only use your E-mail address for important communications related to our practice. We will not give your E-mail address to anyone who is not part of our practice. Please don't send non-essential messages to us, because they slow down our ability to respond to the important ones.
10. **Mistakes.** Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. You should delete messages that are not intended for you.
11. **Other risks.** In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using E-mail needs to use good judgment about these valuable technologies, and must remember that there are alternatives that would be better for some situations.

Patient Acknowledgement and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or receive. I do not have any unanswered questions about what this Agreement requires.

Patient name: ____

Patient email address: ____

Patient signature: ____

Date: ____