GACS

GASTROENTEROLOGY ASSOCIATES
COLORADO SPRINGS

Pikes Peak Endoscopy Center
PIKES PEAK ENDOSCOPY CENTER

1699 Medical Center Point, Colorado Springs, Colorado, 80907

Thank you for choosing Gastroenterology Associates of Colorado Springs.

Please arrive 30 minutes prior to your scheduled appointment time.

You should have received the following paperwork:

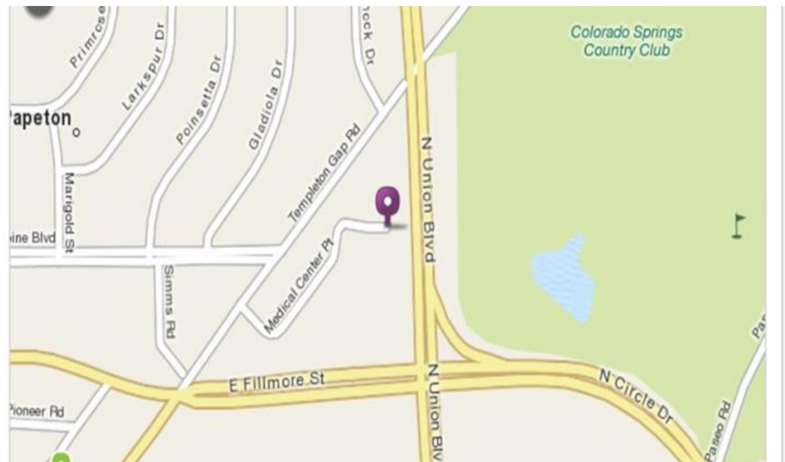
- ☐ Patient Bill of Rights
- ☐ Financial Policy
- ☐ Patient Information Sheet
- ☐ Health Questionnaire with Medication Sheet
- ☐ Acknowledgement Form

Please bring the following to your procedure:

☐ Paperwork:
Patient Information Sheet ● Health Questionnaire ● Acknowledgment Form
☐Photo Identification/Current Insurance Card

Location:

1699 Medical Center Point, 2st Floor
Phone: (719) 632-7101 Fax: (719) 632-4468
www.GACSonline.com



In an effort to decrease possible Covid-19 exposures, our center may restrict visitors. Visitors may be asked to wait outside the building.

Those entering our building are asked to wear a face covering.

Thank you for your cooperation.

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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.*

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 state licensing board through their website http://www.dora.state.co.us/medical or file a complaint by emailing hfintake@cdphe.state.co.us. You may also call 1-800-886-7689 ext 2904. If you have Medicare you may visit the Medicare website at http://www.medicare.gov/ombudsman/resources.asp.

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

Financial Policy

IMPORTANT – PLEASE READ

Patients are responsible for payment of all services provided by Gastroenterology Associated of Colorado Springs, LLP (GACS), Pikes Peak Endoscopy and Surgery Center, LLC, and Anesthesia of the Rocky Mountains, LLC.

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients. The center is fully certified Medicare approved and licensed by the state of Colorado. Anesthesia services are provided by Anesthesia of the Rocky Mountains which is owned by the physicians of GACS.

Fees and Cancelation: Please cancel/reschedule before the times listed below or fees may apply.

Office Visit:	**24 Hours**	**$50.00**
Procedure (EGD/Colonoscopy):	**24 Hours**	**$100.00**
Returned Check Fee:	**$50.00**	

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

APPOINTMENTS:

- Please arrive at least 30 minutes prior to your appointment allow time to complete paperwork, update records and prepare you for procedures (if applicable)

SELF-PAY 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.
  - Acceptable methods of payment: VISA, MasterCard, cash, checks and money orders.

INSURED PATIENTS:

- **Please check with your coverage provider regarding coverage.**
- We will file your primary and supplemental insurance for you as a courtesy to you under surgical provisions. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).
- Although we participate with most insurance companies, it is your responsibility to make sure we are a participating provider with your plan.
- Payment is due at 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.

REFERRALS:

- Please check with your insurance provider to see if a referral is required
- If referral is required: It is your responsibility to request and obtain a referral from your primary care provider.
- 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
- Procedure prior authorization (if applicable) will be obtained prior to procedure on your behalf. You will be notified of your financial responsibility prior to the procedure if prior authorization is not approved. Please be aware that pre-authorization by your insurance company does not guarantee insurance payment for services.

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.

ADDITIONAL FEES: 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) Pathology services (if applicable) and, (4) a professional fee for anesthesia services.

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.

ADDITIONAL INFORMATION: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, and other limited information, for the purpose of notifying me of an unpaid balance. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances and to leave a reminder message on my mobile phone, email and voice mail or answering system.

PATIENT INFORMATION SHEET

Please complete and return

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:____________________

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Office Visit Health Questionnaire

Today's Date:_______________

Patient Name: ____ **Date of Birth:**______________________

Referring Physician :____

Physicians Who Need Visit Notes:____

Reason for today's visit:____		
Please check any of the following symptoms that you are experiencing:		
☐ Change in Bowel Habits	☐ Weight Loss	☐ Blood in Stool/Rectal Bleeding
☐ Diarrhea	☐ Difficulty Swallowing	☐ Anemia
☐ Abdominal Pain	☐ Heartburn	☐ Nausea/Vomiting
☐Abnormal X-ray/CT Scan	When?	
☐ ER Visit	When?	Diagnosis:

Personal History: Have you had the Following?	
Colon Polyps	☐Yes ☐ No
Cancer	☐Yes ☐ No Type:_____________________________________

Family History		**Age at Diagnosis?**
☐ Colon Polyps	Relationship:	
☐ Colon Cancer	Relationship	
☐ Rectal Cancer	Relationship:	
☐ Esophageal Cancer	Relationship:	
☐ Barrett's Esophagus	Relationship:	

Surgical History- Please List Surgical History with Approximate Dates:

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Medical Conditions:			
☐ Asthma	☐ Irregular Heart Beat	☐ HIV	☐ Kidney Disease
☐ COPD (Emphysema)	☐ **Pacemaker/Defib**	☐ Hepatitis B/C	☐ Diabetes Type 2
☐ Sleep Apnea	☐ Heart Failure	☐ **Clostridium Difficile**	☐ Diabetes Type 1
☐ Recent Infection	☐ **Heart Attack**	☐ Cirrhosis	☐ Anxiety/PTSD

Social History	**What?**	**How Often:**	**Quit? List Date:**
☐ Tobacco:			
☐ Marijuana:			
☐ Alcohol:			
☐ IV Drug Use:			
☐ Caffeine:			

Office Visit Health Questionnaire

Preferred Pharmacy: ____________________
Location:____________________

Allergies:

☐No Known allergies

1.____________________Reaction:____________________
2.____________________ Reaction:____________________
3.____________________ Reaction:____________________
4.____________________Reaction:____________________
5.____________________ Reaction:____________________
6.____________________ Reaction:____________________

Medication Name	Dose:	Last Taken:

Review of Systems: Please circle each symptom that **CURRENTLY** applies to you

Constitutional: Abnormal Weight Gain, Abnormal Weight Loss, Chills, Fatigue, or Fever.

Cardiovascular: Chest Pain, Irregular Heartbeat, or High Blood Pressure.

Ears/Nose/Throat: Difficulty Swallowing, Sore Throat, Sinus Allergies, Blurred Vision, Glaucoma, or Sores in Throat.

Endocrine/Allergic/Immunologic: Seasonal Allergies, Diabetes Type 1, Diabetes Type 2, Excessive Thirst, Hair Loss, or HIV Exposure.

Musculoskeletal: Arthritis, Joint Swelling, Joint Pain, Muscle Weakness, Osteoarthritis, or Osteopenia.

Neurological/Psychological: Anxiety, Depression, Frequent Headache, Migraines, or Seizures.

Respiratory: Asthma, Cough, or Sleep Apnea

Skin: Eczema, Jaundice, Rash, or Psoriasis.

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Acknowledgement Form

Please Print and Return

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 Anesthesia of the Rocky Mountains.

I acknowledge receipt and review of the Patient Bill of Rights and HIPPA disclosure. I understand the information that has been presented.

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

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Please Sign Below

_______________________________ _______________________________

Signature Date

____

Printed Name

_______________________________ _______________________________

Signature of Patient Representative Date

_______________________________ _______________________________

Printed Name of Patient Representative Relationship

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ACKNOWLEDGE OF RECEIPT & PERMISSION TO RELEASE INFORMATION

I________________________________ acknowledge that I have received a copy of Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and/or Anesthesia of the Rocky Mountains Notice of Privacy Practices, Financial Policies. These notices describes how Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center and Anesthesia of the Rocky Mountains

- **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.**
- **Patient rights and responsibilities related to billing**

_____________________________________ ___________
Signature of Patient or Representative Date

____
Relationship to Patient

Any patient that is 18 years of age and over and would like to give authorization to disclose health information must give GACS, PPESC, and ARM signed permission.

1 - Name____
Relationship to Patient ___________________________________
_____ All health and financial information.
_____ Limited to ONLY appointment information.
_____ Limited to ONLY financial information.

2 – Name____
Relationship to Patient ____________________________________
_____ All health and financial information.
_____ Limited to ONLY appointment information.
_____ Limited to ONLY financial information.

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1699 Medical Center Point, Colorado Springs, Colorado 80907 Phone:719-387-2133 Fax:719-632-4468

Pikes Peak Endoscopy Center
PIKES PEAK ENDOSCOPY CENTER

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent is simply an effort to obtain permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure (if any) for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below you are indicating that you understand **(1)** the intent of this consent is continuing in nature even after a specific diagnosis has been made and treatment has been recommended; and **(2)** you consent to treatment at this office or any other satellite office under the common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan, the purpose, and the potential risk and benefits of any test(s) or procedure(s) ordered for you with your physician or healthcare provider. If you have any concerns regarding any test(s) or treatment(s) recommended for you by your health care provider, we encourage you to ask questions.

I voluntarily request that a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

____	______________________
Signature of Patient of Patient Representative	Date:
____	______________________
Printed Name of Patient or Patient Representative	Relationship to Patient
____	______________________
Signature of Witness	Witness Title