Colon

Endoscopy Center of Red Bank
365 Broad St, Red Bank, NJ 07701
T: 732-842-4294 www.rbgastro.com

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BOARD CERTIFIED IN
GASTROENTEROLOGY & HEPATOLOGY

Dear Patient: _____ Date: _____

LOCATION: The Endoscopy Center of Red Bank, 365 Broad Street, 2nd Floor Red Bank NJ 07701

PROCEDURE: Colonoscopy **PHYSICIAN:** _____

DATE: _____ **ARRIVAL TIME:** _____*

[ ] morning 7:00am-1130am ***[ ] afternoon 1230pm- 4:00pm***

***Appointment time subject to change:*

4 days prior to procedure you will receive a notification/text asking to confirm or reschedule.
Then 2 days prior you will get a notification /text with your time and procedure information.

*W*elcome and thank you for choosing Endoscopy Center of Red Bank.

Please bring your completed forms with you on the day of your procedure along with your driver's license/ID and insurance card. Leave your jewelry and valuables at home.

Consider any dietary restrictions, fasting time, and medication instructions for the days prior or day of your procedure, a ride home from your procedure by someone who knows you, a responsible adult age 18 or older.

UBER OR PUBLIC TRANSPORTATION IN NOT PERMITTED, *UNLESS ACCOMPANIED BY A FRIEND OR FAMILY*
****NO EXCEPTIONS****

HELPFUL PHONE NUMBERS/CONTACTS:

Endoscopy Center of Red Bank: 732-842-9129

After Hours: 732-842-4294 main number, answering service will page physician on-call

Fax: 732-548-7408

ADH Billing: 732-222-3805

Endoscopy Center of Red Bank Billing (FACILITY ONLY): 732-936-8311

Cancel/Reschedule: _____ at direct phone # _____

MEDICATION INSTRUCTIONS

MEDICATIONS:

You must take your regular medications before your procedure. Please bring a list of all your current medications and their dosages including over-the-counter medications, vitamins, and supplements. You must take your cardiac and blood pressure medications (including the morning of your procedure) with small sips of water only. If you use an inhaler, bring it with you.

CARDIAC PATIENT RESPONSIBILITIES:

Anticoagulant or Antiplatelet therapy: **YOU MUST CONTACT YOUR CARDIAC DR FOR AN APPOINTMENT IF NOT SEEN WITHIN 60 DAYS. WE NEED A CLEARANCE WITH CURRENT EKG. OUR OFFICE WILL SEND REQUEST BUT IT IS THE *PATIENT RESPONSIBILITY* TO FOLLOW UP AND MAKE SURE OUR OFFICE HAS RECEIVED IT *7 DAYS PRIOR* TO YOUR PROCEDURE. IF WE DO NOT RECEIVE IT, YOUR APPOINTMENT MAY BE CANCELLED.

If you are taking any of the following medications, you must consult with your prescribing physician/cardiologist first before stopping and coordinate with our office.

STOP ( ) _____DAYS BEFORE YOUR PROCEDURE:

- ☐ warfarin (Coumadin)
- ☐ Jantoven® Tablets (crystalline warfarin sodium)
- ☐ rivaroxaban (Xarelto)
- ☐ dabigatran (Pradaxa)
- ☐ apixaban (Eliquis)
- ☐ edoxaban (Savaysa)
- ☐ enoxaparin (Lovenox)
- ☐ fondaparinux (Arixtra)
- ☐ desirudin (Iprivask)
- ☐ Clopidogrel (Plavix)
- ☐ Prasugrel (Effient)
- ☐ Ticagrelor (Brilinta)
- ☐ Ticlopidine (Ticlid)
- ☐ Cilostazol (Pletal)
- ☐ dipyridamole/asa (Aggrenox)

Diabetics:

Please check with your doctor who manages your diabetes.

Type 2 Diabetics: Do NOT take your oral diabetes medication while on your clear liquid diet/fasting.

Type 1 Diabetics: Check with your Endocrinologist regarding your insulin.

FEMALE PATIENTS UNDER AGE 55: Please refrain from voiding before you arrive for your procedure as you will be required to provide a small urine sample for a pregnancy test before you receive sedation.

CLEAR (TRANSPARENT) LIQUID DIET

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed.

No Red or Purple liquids (they may look like blood) and **you may NOT have** coffee, milk or anything opaque.

YOU MAY HAVE:

Beverages

1. Water
2. Apple juice
2. Clear (white) cranberry/grape juice
3. Crystal Light®

4. Lemonade
5. Soda, Sprite, ginger ale, seltzer
6. Sports drinks
7. Tea, hot and iced
8. Transparent coconut water
9. Transparent protein drinks ex: Ensure® Clear
   (ok to take Ensure Clear berry flavors up until 5:00PM)

Clear Broth

1. Chicken, beef, vegetable
2. Bouillon
3. Broth
4. Consommé

Desserts

1. Lemon popsicles
2. Lemon ices
3. Favored gelatin "Jello®"

(No red or purple flavors, No fruit chunks)

Miscellaneous

1. Sugar, honey, syrup
2. Clear, hard candy
3. Salt

You may brush your teeth or use mouthwash.

Please do not swallow any liquids 4 hours prior to your actual procedure time

YOU MAY NOT HAVE:

Red or purple colors, coffee, milk, or anything opaque.

Orange colors are permitted.

Alcoholic beverages are not permitted.

Endoscopy Center of Red Bank

Facility Financial Responsibility Statement

We are pleased that you have chosen our facility for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In exchange for providing these services, we ask that you take the time to understand your financial responsibilities to ensure timely and acceptable payment for our services.

1. **I am responsible for knowing the details of my insurance coverage(s) including my responsibility for co-payments, deductibles, co-insurances, and referrals**. I will call my insurance company to obtain this information.

2. I **authorize payment of my insurance benefits to Allied Digestive Health** for the medical services received.

3. I accept responsibility for **payment of any amounts (co-payments, deductibles, and co-insurance) that are not covered by my insurance(s)**.

4. I will provide **all current insurance information (we require both sides of your insurance cards) at the time of service, including a photo ID.**

5. I agree **to have a current and active insurance referral (if applicable) at the time of service issued by my PCP (primary care physician). Otherwise my appointment may be canceled, rescheduled or I will pay in full for my appointment. A doctor's prescription is not a valid insurance referral.**

6. **If I have an endoscopy procedure, I may be responsible for the following fees**: Facility Fee for the Endoscopy Center (in addition to physician fees billed separately by Allied Digestive Health).

8. **If I am without insurance coverage, *Endoscopy Center of Red Bank /Allied Digestive Health*** expects to be paid at the time services are rendered.

9. I understand that **after three (3) attempts to collect any patient balance, my account will be turned over to a collection agency**. I will also be responsible for any and all fees and service charges incurred as a result of a collection agency's involvement.

10. I understand I will be **charged a $35.00 fee if my personal check is returned by my bank**.

I have read the above statements and fully understand and agree to these terms.

X_____ Date:_____
Print Patient Name

X_____
Patient Signature

X_____
Responsible Party/Guardian

Date scheduled. & initials _____ MRN# _____

RESPONSIBILITIES & RIGHTS OF PATIENTS

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities are presented to the patient in the spirit of mutual trust and respect:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary and herbal supplements) and dosages, allergies and sensitivities, and other matters relating to the patient's health.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- It is the patient's responsibility to notify the facility if he/she has not followed the pre-operative instructions given by their physician and/or facility personnel.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so within in the time period required below.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- In the case of pediatric patients, a parent or legal guardian must remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible. Ultimate financial responsibility is the patient's, regardless of the insurance coverage he/she may have.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's Advance Directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.
- Patient's signature represents he/she has received written and verbal information regarding physicians' financial interest in the Facility, Advance Directives, grievance process and on the informed consent process prior to the day of their procedure.

APPOINTMENT CANCELLATION / NO SHOW POLICY

Red Bank Gastroenterology and the Endoscopy Center of Red Bank requires notice for a cancelled appointment. If you are unable to keep your procedure appointment two business day notice is required. There will be a $300 charge for a missed procedure.

It is the policy of the Endoscopy Center of Red Bank (the facility) to require a cash or check cancellation fee of $500 prior to rescheduling an Endoscopic Procedure in our facility canceled for a third time. This fee is non-refundable if the third appointment is cancelled and will otherwise be refunded to you after your procedure within 7-10 business days.

BY SIGNING BELOW:

I acknowledge that the Endoscopy Center of Red Bank has provided me with information regarding:

A. Patient Rights and Responsibilities including cancellation policy☐

B. Physician ownership☐

C. Information about Advance Directives *Including information about how to formulate an advance directive, (if needed)*

Patients Signature indicating awareness of above_____ Date_____

Phone #_____ permission is given to leave a message for arrival time and billing messages only. Authorization will remain in effect until our office receives written notification.

Patient's Rights and Notification of
Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S BILL OF RIGHTS:

Every patient has the right to be treated as an individual with his/her RIGHTS respected. The facility and medical staff have adopted the following list of patient's rights:

PATIENT'S RIGHTS:

To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;

To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;

To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;

To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

To confidential treatment of information about the patient.

Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the Department for statutorily-authorized purposes.

The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;

To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;

To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient;

To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility; and

To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43E-6.

To be informed of their right to change providers if other qualified providers are available

PATIENT RESPONSIBILITIES

- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider and participate in his/her care.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, of required by his/her provider.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care professionals and staff, as well as other patients.

Please note:

- If you believe the care provided to you in a hospital by a doctor was improper, you may file a complaint with the Board of Medical Examiners. However,

- Because the regulation of hospitals is under the jurisdiction of the New Jersey Department of Health and Senior Services (DHSS), if you believe you received improper care at a hospital, you should contact the DHSS Complaint section at (800) 792-9770.

- ***If you need an interpreter:***

If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

Statement of Nondiscrimination:

Endoscopy Center of Red Bank complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Endoscopy Center of Red Bank cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo

Endoscopy Center of Red Bank 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in New Jersey Statutes § 26:2H-53 through 78. In the state of New Jersey, all patients have the right to decide what medical treatment they want or do not want to receive. They can decide in advance what treatment they would want, and put that decision in writing, or they may name someone else who understands and shares their values, to exercise that right for them. Under New Jersey Law, there are three kinds of Advance Directives: Proxy, Instruction Directive ("Living Will") or Combined Directive. http://www.state.nj.us/health/advancedirective/documents/njsa_26.2h.53.pdf
You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative) prior to the procedure being performed. Patients are asked to bring copies of their Advance Directives with them to the surgery center.

Endoscopy Center of Red Bank respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.
If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances:

If you believe the care provided to you in a hospital by a doctor was improper, you may file a complaint with the Board of Medical Examiners. However,

Because the regulation of hospitals is under the jurisdiction of the New Jersey Department of Health and Senior Services (DHSS), if you believe you received improper care at a hospital, you should contact the

State Website: http://www.state.nj.us/lps/ca/bme/bmeform.htm

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman. **Medicare Ombudsman Web site:** http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

This facility is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Complaints or grievances may also be filed through:
AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
Phone: 847-853-6060 or email: info@aaahc.org

Physician Ownership

- Physician Financial Interest and Ownership: Physician Financial Interest and Ownership: The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations. The physician investors have established the ambulatory surgical center, designed primarily for performing endoscopic procedures, and refer patients to the Endoscopy Center of Red Bank for procedures. The Allied Digestive Health Dept of Pathology was developed to facilitate timely, accurate pathologic interpretation of endoscopic biopsies and is staffed by Pathologists with dedicated training in Gastroenterologic Pathology.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Joseph Binns, Robert Gialanella, Gregory Heyt, Yu Jeong Alexis Choi, Howard Hampel, Douglas Weine, Subha Sundararajan

ENDOSCOPY CENTER OF RED BANK
365 BROAD STREET, STE 2 E , RED BANK, NJ

ADVANCED DIRECTIVE–LIVING WILL

On January 11, 1992, a New Jersey law took effect which mandates that all health care facilities ask patients whether they have an Advanced Directive or Living Will. At The Endoscopy Center of Red Bank we have made this a part of our admitting process.

An Advanced Directive or Living Will is a document which allows you to give written instructions to those caring for you indicating the type of health care you would wish to receive or reject in the event you become unable to express these decisions yourself. If you have an Advanced Directive or Living Will, please bring a copy of it with you to the center on the day of your procedure. While you are a patient at the Endoscopy Center of Red Bank, your Advanced Directive WILL NOT be honored. Should you be transferred to a hospital, a copy of your Advanced Directive will be sent with you.

There are three different types of Advanced Directives:

1. A PROXY DIRECTIVE This is a document in which a competent adult names a trusted relative or friend to make health care decisions ☐on their behalf when they are unable to make these decisions.

2. AN INSTRUCTION DIRECTIVE In this document, the person writing it provides written instructions concerning the type of medical treatment ☐they want or do not want performed for them and under what circumstances.

3. A COMBINED DIRECTIVE In the document, a competent adult stated their general wishes regarding the kind of health care they wish to receive but appoints a trusted relative or friend to carry them out. ☐

A brochure containing living will information is available from the Division of Aging. If you wish to receive a brochure, please make your request to:

The Division of Aging
101 South Broad Street
CN807
Trenton, NJ 08625

For more information contact:
State of New Jersey Department of Health and Senior Services
P.O. Box 360, Trenton, NJ 08625-0360
Phone: (609) 292-7837
www.state.nj.us/health/advanceddirective/ ☐

Do you have an ADVANCED DIRECTIVE OR LIVING WILL? _____YES_____NO

If yes, please send or bring it to the center prior to your scheduled procedure.

Patient Signature indicating awareness of above_____ Date_____

Date scheduled. & initials _____ MRN# _____

A Division of

Allied Digestive Health

Patient Registration Form

Please Complete All Information

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth___/___/___ Age: _____ SSN: ___-___-____ Sex: M / F Marital Status: S M D W

Race: _____ Ethnicity: _____ Pref. Language_____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Emp. Address: _____ Emp. Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Rx Card Number: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Emergency Contact Primary Phone: _____ Secondary Phone: _____

Primary Insurance **Please provide a copy of insurance card.**

Insurance Carrier: _____ Policy ID # _____ Group # _____

Insurance Effective Date: ____/____/____ Insurance Co Phone _____

Insurance Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Address if different from patient: _____ City: _____ State: _____ Zip Code: _____

Subscriber's Phone # _____ Subscriber's Date of Birth: ____/____/____ SSN:____-____-___

Subscriber's Employer _____

Secondary Insurance **Please provide a copy of insurance card.**

Insurance Carrier: _____ Policy ID # _____ Group # _____

Insurance Effective Date: ____/____/____ Insurance Co Phone _____

Insurance Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth:_____/_____/_____

Patient/Guardian Signature: _____**Date:**_____

Allied Digestive Health

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

Colonoscopy & Endoscopy Patients ONLY

I understand that Allied Digestive Health's bills are for ADH physicians ONLY: In addition, I may be responsible for, and receive a separate bill (when applicable) from:

1. The Hospital or Endoscopy Center for any facility fees.
2. The Laboratory / Pathologist for any tissue/biopsy testing.
3. The Anesthesiologist for provision of any anesthesia.

I further understand that the final determination of whether an exam is considered "screening" or "diagnostic" cannot be made until the results are complete. I have received and understand a copy of "Colonoscopy: Screening, Surveillance or Diagnostic. I acknowledge that the physician's determination is final and will not be changed for the purpose of reconsideration / overturning of insurance decisions.

_____ _____

Signature of Patient or Guardian Today's Date

For Medicare Patients Requiring Advanced Beneficiary Notice (ABN) ONLY

I understand that Medicare may not cover this service. I have been given a Medicare Advanced Beneficiary Notice of Non-Covered Service (ABN) which explains my options for procedures that may not be covered by Medicare.

_____ _____

Signature of Patient or Guardian Today's Date

Colonoscopy: Screening, Surveillance or Diagnostic?

Your insurance policy may be written with different levels of benefits for preventive versus diagnostic or therapeutic colonoscopy services. This means that there are instances in which you may think your procedure will be billed as a "screening" when it actually has to be billed as therapeutic or surveillance. How can you determine what category your colonoscopy falls into?

Colonoscopy Categories:

Diagnostic/Therapeutic Colonoscopy:

- Patient has past and/or present gastrointestinal symptoms, polyps, GI disease, iron deficiency anemia and/or any other abnormal tests.

Surveillance/HighRisk Screening Colonoscopy:

Patient is asymptomatic (no gastrointestinal symptoms either past or present) but:
- Has a first degree relative with colon cancer or polyps.
- Has a personal history of IBD, colon polyps, or colon cancer
- Is under the age of 50 with a family history of colon cancer or colon polyps

Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (every 2 -5 years, for instance).

***Preventive Colonoscopy with Screening Diagnosis:**

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

*Your primary care physician may refer you for a "screening" colonoscopy, but there may be a misunderstanding of the word screening. You must have no symptoms at all for your colonoscopy to be billed as a screening service.

Before your procedure, you should know your colonoscopy category. After establishing which one applies to you, please call your insurance company to find out your coverage for this service, as well as what, if any, your out-of-pocket responsibility will be.

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

No! The patient encounter is documented in your medical record from information you provided, as well as what is obtained during our pre-procedure history and assessment. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

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

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

Sadly, this happens a lot. Often the representative will tell the patient that "if the doctor had coded this as a screening, it would have been covered differently." However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient. Remember that many insurance carriers consider only patients over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as eligible for a "screening." If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department, and we will investigate the information given.

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: _____

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
   Please note: a Doctor's Prescription is NOT a valid Referral.

2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles and non-covered services.

3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.

4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.

5. I will provide all current (we require both sides of your insurance card) at the time of service as well as a current photo ID.

6. I understand that I will be charged $35 for any check returned by my bank for any reason.

BY MY SIGNATURE BELOW, I ACKNOWLEGE THAT I UNDERSTAND AND AGREE TO THESE TERMS:

_____ _____

Signature of Patient or Guardian Today's Date

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Print Patient's Name _____ Date _____

I, _____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that Allied Digestive Health's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, _____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

Consent for Use and Disclosure of Protected Health Information (PHI)

Use and Disclosure of PHI

Your PHI will be used by Allied Digestive Health, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of the practice.

Requesting a restriction on the Use or Disclosure of your information

You may request a restriction on the use or disclosure of your protected health information. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restriction will be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

Primary Telephone # _____

- € Do not call this number
- € Ok to leave message to call back only
- € Ok to leave message with results and detailed information, including billing.

Secondary Phone # _____

- € Do not call this number
- € Ok to leave message to call back only
- € Ok to leave message with results and detailed information, including billing.

Other persons authorized to receive my health information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Revocation of Consent

You may revoke this consent in the use and disclosure of you Protected Health Information at any time. You may revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose my Protected Health Information in accordance with these guidelines.

_____ _____/_____/_____

Signature of Patient or Patient Representative Date

_____

Printed Name of Patient or Patients Representative

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Practice Administrator who serves as the Privacy Officer.