

PRIME HEALTHCARE

Gastroenterology

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TO: Screening Colonoscopy Patient

FROM: Prime Health Care, PC; GI Group
Avon, CT – 860-674-8830 Wethersfield, CT - 860-529-8670

RE: Screening Colonoscopy Packet

As promised, this is the screening colonoscopy packet you were told you would receive in preparation for your colonoscopy. Please read all enclosed materials very carefully. This packet is designed to eliminate on office visit for individuals deemed low risk for the performance of a colonoscopy. It is our intention that this will enable us to be more considerate of your valuable time. This packet includes:

1. **Colonoscopy Brochure**- this explains the exam and the purpose of the exam. Please read it carefully and keep it for your records.
2. **Patient Intake form**- please fill this out completely. This information will allow us to determine if we can schedule you directly for your procedure versus needing to be seen first in the office. This form must be **completely filled out** before we can schedule you for your exam.
3. **Patient Registration, HIPAA Patient Calling Information, and HIPAA Privacy Practices forms**- these forms are necessary information needed for your file. Without this information we will not be able to bill your insurance company or contact you with any results that come into our office.
4. **Consent Form**- please read this form carefully. The consent form gives your physician permission to perform your colonoscopy. Only sign this form if you have read and thoroughly understand its contents.

Once completed, please mail **ALL FORMS** completely filled out to our office in the enclosed postage-paid envelope provided. The sooner we receive these forms, the faster we can contact you to schedule you for your procedure.

If you have any questions regarding this packet or do not understand the instructions, please call our office at (860)674-8830. Thank you for your time; we look forward to serving you!



Allergies to Medicine:

Are you allergic to any medication? Yes No Are you allergic to latex? Yes No
If yes, please name medications & reactions: _____

Have you ever had problems with Anesthesia? Yes No

Medications:

Do you take aspirin or arthritis medication (Ibuprofen, Naproxen, Aleve, Motrin, Advil)? Yes No
If yes, please name medication & frequency: _____

Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)? Yes No
If yes, please name medication & frequency: _____

Please list other medications you are taking (include "over-the-counter" medicine and doses)

Social History/Martial Status:

___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Circle the number of years of formal education you have completed.
8 9 10 11 12 13 14 15 16 >16

Your occupation: _____ Retired ___ Unemployed ___ Disabled ___

Do you/have you ever used tobacco? ___ Yes ___ No Packs per day? ___ Years? ___ Date Quit? ___

Do you use chewing tobacco? ___ Yes ___ No Frequency? ___ Years? ___ Date Quit? ___

Do you drink alcohol? ___ Yes ___ No ___ Beer ___ Wine ___ Liquor How often? ___ How much? ___

Have you ever used street/illicit drugs? ___ Yes ___ No Type _____ Last use _____

FAMILY HISTORY

Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

- | | | | |
|--------------------------------|--------------------------|----------------------------------|---------------------------|
| _____ Colon polyps | _____ Breast Cancer | _____ Skin cancer (ie. Melanoma) | _____ Hepatitis |
| _____ Colon cancer | _____ Prostate Cancer | _____ Liver cancer | _____ Bleeding problems |
| _____ Rectal cancer | _____ Stomach cancer | _____ Pancreatic cancer | _____ Ulcerative Colitis |
| _____ Uterine/ Cervical cancer | _____ Small bowel cancer | _____ Kidney/Ureter cancer | _____ Celiac Disease |
| _____ Ovarian Cancer | _____ Esophageal cancer | _____ Crohn's Disease | _____ Gallbladder Disease |

Other Cancer (please describe) _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____



Office _____
Physician _____

PATIENT REGISTRATION SHEET

PATIENT INFORMATION

SSN# _____

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Address: _____

City _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Which telephone number is best to reach you? Please check Home Work Cell

Sex (M/F): _____ Date of Birth: _____ Employer: _____

Can we contact you via email? Yes No Email Address: _____

PCP: _____ Referring Dr: _____

Marital Status (S/M/W/D): _____ Race: _____ Patient Prefers Not to Answer _____

Emergency Contact: _____ Relationship: _____

Emergency Home Phone: _____ Work: _____ Cell: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____ Patient Relationship to Policy Holder: _____

Policy ID #: _____ Policy Group #: _____

CLAIM ADDRESS: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____ Patient Relationship to Policy Holder: _____

Policy ID #: _____ Policy Group#: _____

CLAIM ADDRESS: _____

LOCAL PHARMACY NAME: _____ PHONE NUMBER: _____

ASSIGNMENT OF BENEFITS STATEMENT

I hereby authorize direct payment of medical/surgical benefits to PRIME Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize PRIME Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

Signature of Beneficiary/Guarantor _____ Date: _____

Do you want to discuss a living will or advanced directives? _____ Yes _____ No _____ I have a living will.

PRIME HEALTHCARE, PC
Gastroenterology/Internal Medicine

HIPAA PATIENT CALLING INFORMATION

Name: _____

Date of Birth: _____

With whom do you allow us to share your personal medical information?

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

How may we contact you?

Home Phone: _____

- _____ DO NOT leave a message
- _____ Leave brief message, return #
- _____ May leave a detailed message

Work Phone: _____

- _____ DO NOT leave a message
- _____ Leave brief message, return #
- _____ May leave a detailed message

Cell Phone: _____

- _____ DO NOT leave a message
- _____ Leave brief message, return #
- _____ May leave a detailed message

**I understand that it is my responsibility to notify the office of any changes in my calling information.

SIGNATURE _____ **DATE** _____

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PATIENT INFORMED CONSENT FORM

1. PROCEDURE AND ALTERNATIVE: I, _____, (patient/guardian) give consent for the doctors of Prime Health Care, PC: GI Group to perform a **screening colonoscopy**.
2. I understand the reason for the procedure is for colon cancer screening/prevention.
3. RISKS/DANGERS: I understand that this procedure may have risks and dangers that can include, but are not limited to: perforation (puncture of the colon wall), missed lesions, bleeding, infection, cardiac complications including heart attack, abnormal heart rhythms, and respiratory issues.
4. ANESTHESIA: A doctor or specially trained nurse will give me medicine to keep me from feeling the pain of the procedure. This is called conscious sedation/anesthesia. The medicine could make me relax or sleep. This medicine could cause problems. The doctor or specially trained nurse will decide what medicine to give me.
5. ADDITIONAL PROCEDURES: If my physician discovers a different unsuspected condition at the time of my procedure, I authorize her/him to perform such other procedures as deemed necessary.
6. RESULTS NOT GUARANTEED: I understand that a screening colonoscopy is the best test to prevent colon cancer but does not completely eliminate the risk of subsequently developing colon cancer.
7. FINANCIAL RESPONSIBILITY: I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the insurance carrier for my procedure(s). **In addition, I am aware that if I cannot attend my scheduled procedure(s), I must call at least 48 hours in advance to avoid a \$150 no show /cancellation fee.**
8. PATIENT'S CONSENT: I have read and fully understand all materials offered to me in regards to this procedure. I have read and fully understand this consent form. My questions have been answered. I have no more questions.

Patient signature

Date

Patient Date of Birth

If you wish to be seen in the office prior to your colonoscopy, please check here and do not sign the consent. Please include this form with all the other forms in the packet and mail back to us.

**Acknowledgement of Receipt of Notice of
Privacy Practices**

Prime HealthCare, P.C.
F.V. Gastroenterology Group
44 Dale Road, Avon, CT 06001
Privacy Officer (860) 263-0253 EXT 231

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I acknowledge and grant my authorization for publication of my personal, identifiable, and/or proprietary information through the AllscriptsTouchworks EMR (Electronic Medical Record) system for use and disclosure as described in paragraph B.3.b on pages 4 to 5 of this medical practice's Notice of Privacy Practices. I also understand that use of the Allscripts Touchworks EMR system may result in my patient information being able to be accessed by healthcare providers other than my Prime HealthCare providers, however I understand and acknowledge this is limited to only those healthcare providers who are part of a sub group of the St. Francis Physician Hospital Organization (PHO) who also are using the Allscripts Touchworks EMR system. I further understand and acknowledge that such providers are also obligated to safeguard and protect my healthcare information in accordance with all HIPAA Privacy and Security regulations. I acknowledge and agree that my Prime HealthCare provider ("Group") will enter my protected health information ("PHI") in a database maintained by the Saint Francis Hospital and Medical Center (the "Hospital"). The PHI maintained in the database will be used by this Group for treatment, payment and health care operations purposes. The Group may also disclose my PHI maintained in the database to another provider (i) for treatment purposes, (ii) for payment purposes and (iii) for health care operations if I have or had a relationship with the other provider and only for the following reasons: (a) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; or (b) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing services; or (c) health care fraud and abuse detection or compliance. The Group may also disclose my PHI maintained in the database to the PHO as a Business Associate of the Group for health care operational purposes, including without limitation, quality and utilization review of health care services.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain: _____ Reasons for refusal: _____

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Internal Medicine

Sybil L. Sandoval, M.D.
Wayne Chen, M.D.

PAYMENT POLICY

Name of Patient: _____ D.O.B. _____

- 1. Insured Patients. We do participate with many insurance plans and will gladly submit to them your information. Co-payments are paid at the time of the service. If you do not have your co-pay we will exercise our option to reschedule your visit. The co-pay is part of your contract with your insurer. You are responsible for your co-pay at the time of service. To not collect the co-pay is fraud on our behalf. Deductibles will be billed to you after notification from your insurer to this office. You must present a valid insurance card at the time of service. Knowing your insurance is your responsibility. You need to take the responsibility to contact your insurance company for the particulars of your coverage.
2. Non-Insured Patients. If you are not insured by a plan that we participate with or have no insurance coverage at all, payment is expected at the time of your visit. If you cannot make payment in full, a minimum payment of \$50 is required prior to your seeing the doctor. This will not be billed out for later payment. You must pay prior to seeing the doctor. A procedure requires a \$100 deposit. Both the \$50/100 is a deposit and is not the full amount that you are responsible to pay. We will gladly work with you on a payment plan.
3. Screening Colonoscopy. A colonoscopy is considered diagnostic when the patient is experiencing a symptom that requires further examination. A screening colonoscopy is done when there is an absence of symptoms or problems or your family physician has determined that this be done because of age or family medical history. A screening colonoscopy may fall under the wellness/preventive benefits of your policy. If this is the case, some insurers are not covering this procedure. While we may obtain the pre-cert for this procedure it will only be covered if your policy includes it. This is very important that you personally look over your policy and that you call your insurer to make sure they will pay for this screening.
4. Payment Methods. We accept Visa, MasterCard, Discover, Checks, or cash.
5. Non-payment. If you account is 75 days past due, you will receive a final letter stating that we exercise our option to collect moneys owed to us by turning the account over to Transworld Systems, Inc. While we hesitate to do this, we will pursue moneys owed to the practice. Also please be aware that if a balance remains unpaid, you may be discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive a certified letter indicating that you have 30 days to find other medical care.

****While our physicians are dedicated to your health care, you the patient must recognize that in order to continue serving you we must charge for services as they are delivered to you. It is your responsibility to pay for these services as they occur so that our physicians and staff may continue to serve you 24-7. Thank you. ****

I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all Medical services rendered thereof:

Signature of patient responsible party

Todays Date

Printed Name: _____

Relationship to Patient: _____