



Procedure Financial Disclosure

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

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

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

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

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

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

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

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

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

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

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

Acknowledgement of Receipt of Procedure Financial Disclosure

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

Patient Signature

Date

Print Name

FINANCIAL POLICY AND PATIENT AGREEMENT

IMPORTANT – PLEASE READ

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

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

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

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

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

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

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

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

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

ADDITIONAL CHARGES:

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

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

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

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

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

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

Patient Signature

Witness Signature

Date

Preparing for your ENDOSCOPY

ONE WEEK BEFORE 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 2 hours before your procedure time.

DAY BEFORE YOUR PROCEDURE:

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

DAY OF YOUR PROCEDURE:

- You **MUST** discontinue eating solid foods **8 hours before your procedure**. You may continue clear liquids up to 2 hours prior to your procedure. *You MUST stop eating solid foods 8 hours before your procedure.*
- You may take your medications (with water) up until 2 hours before your procedure time.

If you have any questions, please call **719-632-7101** and **Press 2** to speak to a scheduling specialist.



4110 Briargate Pkwy
Suite 100
Colo Spgs, CO 80920



1699 Medical Center Pt
Colo Spgs, CO 80907
(719)632-7101
www.GACSONline.com



1699 Medical Center Pt
Colo Spgs, CO 80907

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.

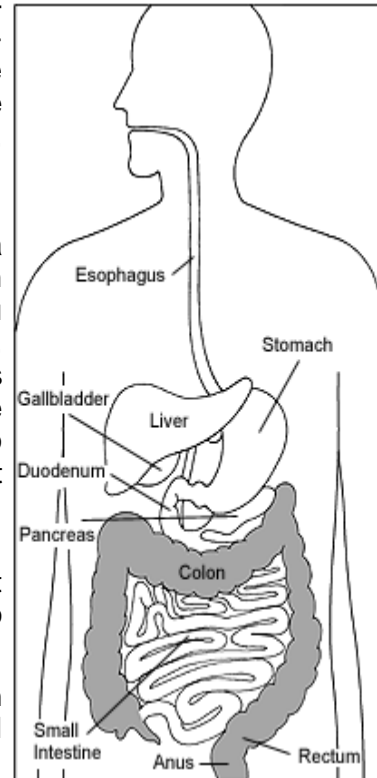
The physician can see abnormalities, like ulcers, through the endoscope that don't show up well on x-rays. Your physician can also insert instruments into the scope to remove samples of tissue (biopsy) for further tests.

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 4 days** 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



1699 MEDICAL CTR PT
COLO. SPGS., CO 80907



4110 BRIARGATE PRKWAY
SUITE 100
COLO. SPGS., CO 80920

Memorial Health System
INFORMED CONSENT FOR OPERATION OR PROCEDURE

Print Name _____ Patient's Date of Birth _____

I authorize _____ to perform the following procedure: (NO ABBREVIATIONS/ACRONYMS)
___ Right ___ Left ___ NA

I understand the reason for the procedure is: _____

No guarantee or assurance has been made to me as to the results of the procedure.
I also authorize any additional procedures deemed necessary due to unsuspected conditions found during the procedure.

ALTERNATIVES: _____

RISKS: Any procedure involves some risks and hazards. The most common risks of surgery include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia or death. Additional risks of this procedure include but are not limited to: _____

- The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.
- Other qualified medical practitioners may perform important tasks in my procedure (i.e. opening, closing, removing tissue, administer anesthesia) based on their scope of practice under the direct supervision of my physician.
- Medical observation or participation may occur during my procedure by healthcare team members, students and designated sales representatives under the direct supervision of my physician.
- Any tissue or hardware removed will be disposed of safely by the hospital.
- Memorial Health System will release applicable health information to device manufacturer(s) per state and/or federal regulations in order to track any implanted device in case of a recall or failure.
- Photographing/videotaping may be done for the purpose of diagnosis and/or treatment as determined by my physician.
(Photography for educational purposes requires a separate consent)

- A. ___ NA ___ I agree ___ I do not agree to authorize healthcare student(s) to participate in my procedure
- B. Moderate sedation: ___ NA ___ I agree ___ I do not agree to the use of moderate sedation based on the explanations of the risks, benefits and expected results of this type of sedation. ___ Per Anesthesia recommendation
- C. Allograft/xenograft: ___ NA ___ I agree ___ I do not agree to the use of allograft/xenograft based on the explanations of the risks, benefits and expected results of its use. (See information sheet)
- D. Blood transfusion: ___ NA ___ I agree ___ I do not agree to the use of blood or blood products during and after the procedure as needed based on the explanations of the risks, benefits and expected results (See information sheet)

PATIENT CONSENT: I understand the information my physician/LIP gave me. I was given the opportunity to ask further questions.


Signature of Patient or Legal Surrogate: _____ Date: _____ Time: _____
Relationship to Patient _____

PHYSICIAN or LIP DECLARATION: I have explained the operation/procedure, anticipated benefits indications, alternatives, and material risks pertinent to this procedure. I have answered my patient's questions. The patient has been adequately informed and has consented.

Signature of Physician or LIP: _____ Date: _____ Time: _____

INTERPRETATION: This form was interpreted for the patient /representative in _____ language by operator # _____

NA = Not Applicable
Page 1 of 2


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

2-18-11
1200029
This Consent is available in Spanish and the content is identical
Timeout Conducted: Date: _____ Time: _____ Signature: _____

MUST PLACE ID LABEL
IN THIS BOX ONLY

SEDATION / MODERATE

Patient's Name _____ Physician _____ Date _____

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

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

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

Allergies: NKA or update composite list
Pregnancy/LMP _____

C: Patient Physical Exam

Vital Signs: (BP, HR, RR, baseline SpO2) Weight _____
See Nurses Notes _____

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

D: Anesthesia Classification

Check Anesthesia Classification below:
 Anesthesia Consultation Yes No

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

E: NPO Time/Date

Last Food _____
Last Fluid _____

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

Procedure: _____

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

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

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

Physician Signature _____ Date: _____



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

HOME/DISCHARGE MEDICATION PROFILE

CURRENT Medications/Supplements/Herbals:

Patient Instructions:

1. Complete this section (outlined in blue) with your current medication/supplements/herbal information. Copy the information exactly as printed on your prescription bottles.

Healthcare Provider Instructions
Please indicate medications to be stopped.

At Home or Outpatient Prescriptions and Over the Counter Medications:

Discharge Process for Health Care Provider

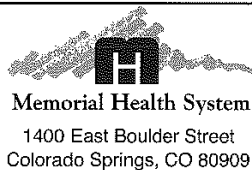
Drug Name <small>(List only those MEDS currently being taken)</small>	Route	Dose	Frequency	Reason for Taking	Stop	Comments
1					<input type="checkbox"/>	<input type="checkbox"/>
2					<input type="checkbox"/>	<input type="checkbox"/>
3					<input type="checkbox"/>	<input type="checkbox"/>
4					<input type="checkbox"/>	<input type="checkbox"/>
5					<input type="checkbox"/>	<input type="checkbox"/>
6					<input type="checkbox"/>	<input type="checkbox"/>
7					<input type="checkbox"/>	<input type="checkbox"/>
8					<input type="checkbox"/>	<input type="checkbox"/>
9					<input type="checkbox"/>	<input type="checkbox"/>
10					<input type="checkbox"/>	<input type="checkbox"/>
11					<input type="checkbox"/>	<input type="checkbox"/>
12					<input type="checkbox"/>	<input type="checkbox"/>
13					<input type="checkbox"/>	<input type="checkbox"/>
14					<input type="checkbox"/>	<input type="checkbox"/>

DISCHARGE MEDICATIONS

MEDICATION <small>(Include Strength)</small>	DIRECTIONS <small>(Dose/Route/Frequency)</small>	Reason <small>(Indication)</small>	NEXT DOSE	LAST DOSE

- | | |
|---|---|
| <input checked="" type="checkbox"/> Current medications/supplements/herbals list has been reviewed. Recommend continuing as listed, EXCEPT METFORMIN after anesthesia or contrast dye.
<input type="checkbox"/> Recommend discussing home medications with your primary care physician.
<input checked="" type="checkbox"/> If your medications have been held or changed, follow up with your Primary Care Physician.
<input checked="" type="checkbox"/> Bring this form to follow up visits | <input type="checkbox"/> Unable to Obtain Medication History.
Reason: _____
Data Source: <input type="checkbox"/> Patient <input type="checkbox"/> Family
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Copy given to patient/family |
|---|---|

FAXED to Dr. _____
 Additional medications on Supplemental Page
 Pre Surgery RN Signature: _____ Date/Time _____
 Admitting RN Signature: _____ Date/Time _____
 Discharge RN Signature: _____ Date/Time _____



Patient Label

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

Name _____ Surgery / Procedure _____ Current WT _____ HT _____

Check (Y)es or (N)o for each item: Y N Comments:

Y N Comments:

Heart Disease If yes, who is your Managing Doctor:			Sleep Apnea If yes, who is your Managing Doctor:		
Heart murmur			Do you snore louder than talking/loud enough to be heard through closed doors		
Chest pain with exercise			Often tired, fatigued or sleepy during the day		
Heart Attack			Has anyone noticed you stop breathing during your sleep		
High Blood Pressure			CPAP/BIPAP		
Do you get short of breath walking 2 flights of stairs			Anesthesia		
Echo/Stress Test/past yr			Jaw Problems		
EKG / past yr			Motion Sickness		
Pacemaker / Defibrillator			Malignant Hyperthermia (you or your family member)		
Lung Disease If yes, who is your Managing Doctor:			Infections		
Cold/Flu last 2 weeks			MRSA (Methycillin Resistant Staph Aureus)		
Emphysema/COPD			VRE (Vancomycin Resistant Enterococcus)		
Asthma			Hepatitis		
Oxygen Use (flow-route)			HIV		
Chest Xray in past year			History of/or active Tuberculosis (TB)		
Diabetes If yes, who is your Managing Doctor:			Safety		
Age Diagnosed			History of falling in last 3 months		
Blood Glucose monitoring		Range _____	Unsteady walk or use of cane/walker		
General Health			Allergies <input type="checkbox"/> NO, if YES Please complete the following:		
Bleeding Tendencies			Allergies to Medications		Reaction
Blood Clots / Phlebitis					
Kidney Failure Problems					
Liver Problems					
Ulcers / Acid Reflux					
Rheumatoid Arthritis					
Polio / Multiple Sclerosis					
Spinal Cord / Head Injury					
Seizure Disorder					
Mental Disability					
Cancer			Food Allergies		
Other Medical Problems:			Latex/Tape		
Social History			Iodine / IV contrast		
Current Smoker			Other:		
# of years smoking / pks Day			Surgery History		
Do you want smoking cessation info			Year	Surgery	Anesthesia Problems
Year you quit smoking					
Alcohol - use / amount					
Recreational drugs					
Do you feel safe at home			PLEASE COMPLETE THE HOME/DISCHARGE MEDICATION PROFILE SHEET		
If not, what do you need					
Last Menstrual Period		____/____/____			

Patient/Responsible Party _____ Contact Person / Phone _____

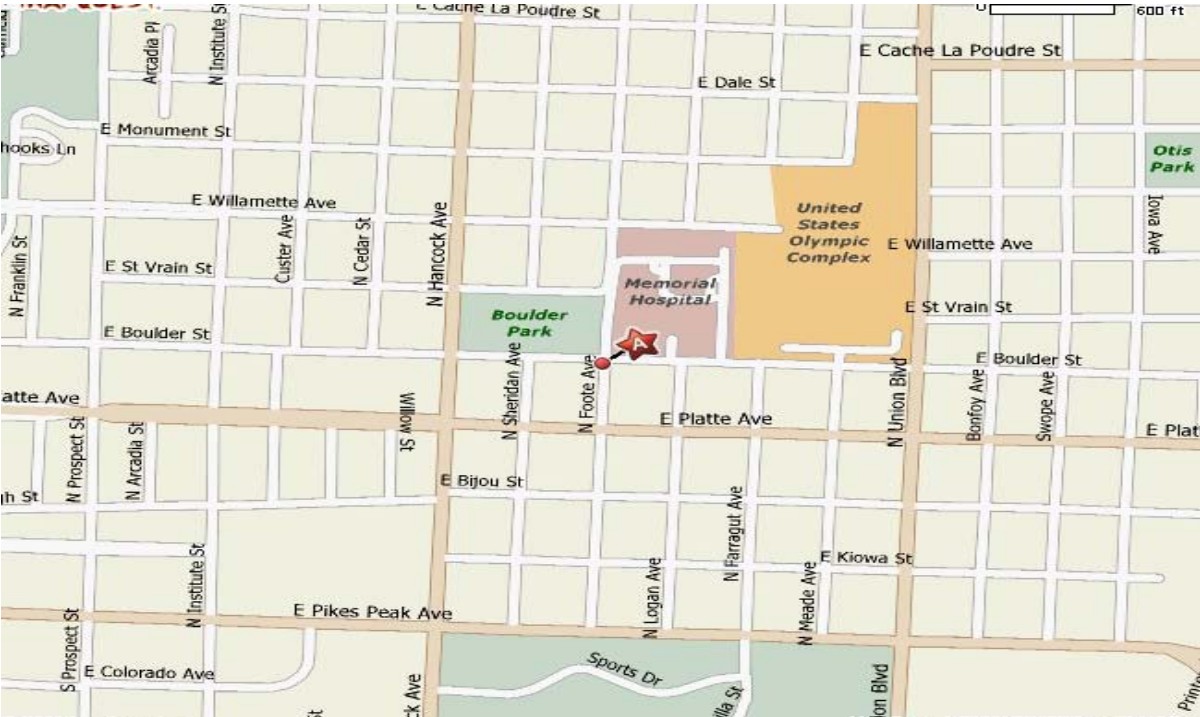
PSC RN _____ Date _____ Admit Nurse _____ Date: _____



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

PATIENT LABEL HERE

MEMORIAL HOSPITAL MAPS



MEMORIAL MAIN 1400 EAST BOULDER STREET



MEMORIAL HOSPITAL NORTH 4050 BRIARGATE PARKWAY