

**Cary Gastroenterology Associates**  
**Colonoscopy Consent Form**

**Your physician has requested that you undergo a procedure called Colonoscopy.** Colonoscopy is a procedure that enables the physician to see inside the colon or large intestine. The colon is examined with a long flexible tube called a colonoscope. This instrument is a lighted tube composed of either very thin flexible fibers, or a tiny video camera that enables the physician to see around bends or corners.

**This procedure is useful in detecting diseases of the large intestine,** including polyps, cancer and other diseases that can result in diarrhea, weight loss, abdominal pain or blood in the stool. If an abnormality is detected it often can be biopsied or removed. Polyps can often be burned out with a procedure called polypectomy which uses electric current to burn the polyps off the wall of the colon.

**As with any examination certain risks exist. These include but are not limited to: bleeding, perforation, medication reactions, life threatening events, and missed lesions.** With this procedure there is the risk of bleeding from biopsy or polypectomy site. Bleeding can often be stopped using special tools at the very same time of colonoscopy. Rarely, blood transfusions or surgery may be required in this situation. Perforation or puncture of the colon is an additional risk of this procedure, although this is a rare occurrence. If perforation occurs surgical correction is necessary. Medication reactions and life threatening events are rare occurrences and you are monitored closely for them during and following the procedure. As with many tests, it is not perfect and lesions can be missed. **Every effort is made to minimize chances of these risks.** If you have any questions concerning this test, they will be answered for you before you sign this form.

I certify that I have read/been read and understand the contents of this informed consent.

In addition, all of my questions have been answered; and all complications, risks, and benefits have been explained to my satisfaction.

I hereby authorize Dr. \_\_\_\_\_ and/or such assistants as may be selected by him to perform the above mentioned procedure on \_\_\_\_\_.  
(Name of Patient)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Raleigh Endoscopy Center Patient Health History Sheet:

Please fax this form to the endoscopy center location to which you have been assigned (listed below)  
**at least 2 weeks prior to exam date**

## Locations:

**Main:** 2417 Atrium Dr. (Fax)919-791-2061    **North:** 8300 Healthpark (Fax)919-256-7981    **Cary:** 1505 SW Cary Parkway (Fax)919-792-3061

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Procedure Date \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

\*\*\*\*\*DRIVER MUST REMAIN WITH YOU AT THE ENDOSCOPY CENTER AT ALL TIMES\*\*\*\*\*

## **Allergies: Medication and Food Allergies(Please List Below):..... Include any allergy to eggs or soy**

<u>Name of medication/Food</u>	<u>Reaction to Medication/Food</u>
1. _____	_____
2. _____	_____
3. _____	_____

## **MEDICATIONS: LIST ALL (BOTH PRESCRIPTION & NON PRESCRIPTION, ALSO ALL SUPPLEMENTS & VITAMINS):**

<u>MEDICATION NAME</u>	<u>DOSE TAKEN</u>	<u>FREQUENCY</u>	<u>REASON TAKEN</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. Do you take a blood thinner?	Yes	No	Name: _____

## **Do you have any of the following? IF YES-contact your GI physician's office for further evaluation**

Trouble Breathing or Anaphylaxis to Latex or Rubber Products?	Yes	No
Oxygen at Home to Help You Breathe?	Yes	No
A Letter Stating You Are Difficult to Intubate?	Yes	No
Problems with Anesthesia (if so explain)	Yes	No
An Implanted AICD for Your Heart?	Yes	No
Currently Pregnant or Breast Feeding?	Yes	No

## **Have You Ever Been Diagnosed With the Following: (Please Circle if You Have Had or Currently Have)**

Congestive Heart Failure	Colon Cancer	Seizures (date of last) _____
Irregular Heart Beats	Cirrhosis	Stroke/TIA/CVA (date of last) _____
Chest Pain/Angina	Liver Disease	Infectious Diseases (type) _____
Heart Attack (Date) _____	Hepatitis(type) _____	Bleeding/Clotting Disorder (type) _____
Heart Stents (number) _____	Colostomy Bag	Cancer(type) _____
Shortness of Breath	Colitis/Crohns	Chemotherapy or Radiation: Dates _____
Sleep Apnea	Anemia	Shingles
COPD	C. Difficile	HIV/AIDS
Kidney Failure/Dialysis	Diabetes	Do you smoke? _____ Alcohol per week _____
High Blood Pressure		
Other/Misc : (please list) _____		

## **Surgeries: Please List All Major Surgeries**

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

## COLONOSCOPY INSTRUCTIONS

Preparation is key to a successful colonoscopy. Please read and follow these directions very closely.

### **MY PROCEDURE INFORMATION:**

Procedure Date: \_\_\_\_\_ Procedure Time: \_\_\_\_\_

Arrival Time: \_\_\_\_\_ Location: \_\_\_\_\_

### **ITEMS TO PURCHASE:**

1. **Prescription Prep Solution:** This is a medication we sent directly to your pharmacy. You will receive one of the following: Suprep, Clenpiq, Moviprep, or Golytely/Nulytely/Trilyte.
2. Flushable wet wipes are suggested and helpful.
3. A zinc oxide barrier cream, such as Desitin, is also helpful to soothe any skin irritation.

### **CALL CARY GASTROENTEROLOGY IF YOU:**

- ❖ Require ANTIBIOTICS for invasive procedures ❖ Have a LATEX ALLERGY
- ❖ Are on a blood thinner (Coumadin, Pradaxa, Xarelto, Eliquis, Arixtra, Plavix, Effient)
  - ❖ Take more than 81mg of ASPIRIN per day.

### **THE FOLLOWING ARE ABSOLUTE REQUIREMENTS FOR YOUR PROCEDURE:**

- ❖ A licensed driver (age 18 and older) MUST accompany you at check-in and remain during your test.
- ❖ Taxis are prohibited. Driving yourself is prohibited. You cannot walk or ride a bike home. ❖ Plan on spending 3 hours at the procedure center. Do not bring jewelry or valuables.
- ❖ Wear comfortable clothing. Do NOT wear contact lenses. Bring warm socks.
- ❖ All medical clearances must be in our office prior to your procedure. ❖ You should have NOTHING BY MOUTH for 3 hours prior to your procedure.

# PREPARING FOR YOUR PROCEDURE – THE PREP

## 7 DAYS PRIOR TO YOUR PROCEDURE:

Day/Date \_\_\_\_\_

- ❖ **STOP:** Iron supplements, Vitamin E., St. John’s Wort, Fish Oil, and Gingko products ❖
- STOP:** Anti-inflammatory drugs (NSAIDS): Ibuprofen, Advil, Motrin, Aleve, Celebrex, Mobic. ❖ TYLENOL may be used freely, including the day of procedure.
- ❖ **Your physician may ask you to stop blood thinners, including aspirin, between now and 5 days pre-procedure.** Check with Cary Gastroenterology to clarify this.

## 3 DAYS PRIOR TO YOUR PROCEDURE:

Day/Date \_\_\_\_\_

- ❖ **IMPORTANT DIET RESTRICTIONS:**
  - **NO** fruits/vegetables with seeds: cucumbers, tomatoes, squash, broccoli, beans, kiwi, strawberries, and raspberries.
  - **NO** granola bars, high grain cereals/breads, oatmeal, nuts, corn, or popcorn.

## 1 DAY PRIOR TO YOUR PROCEDURE (PREP DAY):

Day/Date \_\_\_\_\_ ❖

**Breakfast:** You may have a light, low-fiber breakfast. **NO** fruit, vegetables, nuts, seeds, granola, or multi-grain breads. See samples below.

- ❖ **Snack:** You may enjoy a small, low-fiber snack before 12pm. See samples below.

Sample Breakfast Foods	Sample Snacks (Before 12pm)
❖ 1 Cup low-fiber cereal (e.g. corn flakes)	❖ 4 ounces lean meat (1/2 chicken breast)
❖ 2 Eggs	❖ Small baked potato, no skin
❖ 1 Plain bagel with cream cheese	❖ 1 Cup of pasta
❖ 2 Pieces white toast	❖ 10 small pretzels
❖ 1 cup milk; fruit juice without pulp	❖ 1/2 cup cottage cheese
❖ 1 cup yogurt without fruit	❖ 1 cup fruit or vegetable juice without pulp

- ❖ **12:00PM:** You should only consume CLEAR LIQUIDS for the remainder of the day.
- ❖ **DO NOT** eat or drink anything colored red or purple; avoid dark colas. ❖ **DO NOT** drink milk. **DO NOT** drink alcohol.

Sample Clear Liquids
❖ Water, tea, Gatorade, Sprite, ginger ale, or Mountain Dew
❖ Chicken broth or vegetable broth
❖ Popsicles (without pulp or fruit pieces; no red or purple)
❖ Grape, apple, or white cranberry juice.
❖ Clear hard candy (lemon drops, lifesavers, Jolly Ranchers; no red or purple)
❖ Black coffee – <b>NO CREAMER.</b> (We <u>prefer</u> you do NOT drink coffee at all)

❖ **6:00PM: COMPLETE THE FIRST PART OF YOUR PREP.** Follow the instructions below for the particular prep you were prescribed:

☐ **SUPREP:**

- Pour ONE (1) 6-ounce bottle of SUPREP liquid into the mixing container provided.
- ADD cool drinking water to the 16-ounce line on the container and mix.
- Drink ALL the liquid in the container.
- You MUST drink two (2) more 16-ounce containers of water over the next hour.

☐ **CLENPIQ:**

- The kit includes two (2) bottles of premixed solution.
- Drink ALL of one pre-prepared bottle. No need to mix with anything. (Either bottle is fine, as they are the same solution).
- Using the cup included with your kit, drink 5 (FIVE) 8-ounce cups of clear liquid (upper line) over the next 5 hours.

☐ **MOVIPREP:**

- Empty ONE (1) pouch A and ONE (1) pouch B into the disposable container.
- Add water to the top line of the container.
- MIX to dissolve. DRINK the entire container over 60-minutes. ▪ Drink an ADDITIONAL 16-ounces of clear liquid or water.

☐ **GOLYTLEY, NULYTELY, GAVILYTE, HALFLYTELY OR TRILYTE:**

- ADD water to the "Fill To" level mark of the prep container. SHAKE until completely dissolved (this can be done in advance, then chilled).
- Drink HALF the prep solution. You should drink a minimum of 8-ounces of the solution every 10 MINUTES. You can drink it faster if you are able.

❖ Continue drinking clear liquids until bedtime.

❖ **If you do not have a bowel movement by 9:00PM** call our on-call provider (919-816-4948)

**MEDICATION ADJUSTMENTS:**

- ❖ Please take your blood pressure or heart medications at your normal time with sips of water
  - ❖ If you are on insulin or oral diabetes medications, please consult with your physician to discuss adjusting these medications. Typically, we recommend NOT taking your diabetes medications the day of the procedure, as you will be fasting that day.
- ❖ STOP all diuretics (water pills) the day before your procedure. Do not take them the day of the procedure.

CONTINUE TO FOLLOW SECOND HALF OF PREP INSTRUCTIONS BELOW

**PROCEDURE DAY:**

Day/Date \_\_\_\_\_

❖ **5 HOURS PRIOR TO YOUR ARRIVAL TIME:** Drink the 2<sup>nd</sup> PART of your prep, as follows:

**SUPREP:**

- Pour ONE (1) 6-ounce bottle of SUPREP liquid into the mixing container provided.
- ADD cool drinking water to the 16-ounce line on the container and mix.
- Drink ALL the liquid in the container.
- You MUST drink two (2) more 16-ounce containers of water over the next hour.

**CLENPIQ:**

- Drink the second bottle of premixed solution.
- Drink an ADDITIONAL 3 (THREE) 8-ounce cups of clear liquid (upper line).

**MOVIPREP:**

- Empty ONE (1) pouch A and ONE (1) pouch B into the disposable container.
- Add water to the top line of the container. MIX to dissolve.
- DRINK the entire container over 60-minutes.
- Drink an ADDITIONAL 16-ounces of clear liquid or water.

**GOLYTLEY, NULYTELY, GAVILYTE, HALFLYTELY OR TRILYTE:**

- Drink the remaining HALF the prep solution. You should drink a minimum of 8-ounces of the solution every 10 MINUTES.

❖ **IMPORTANT:** You should have **NOTHING BY MOUTH** beginning **3 hours** prior to your procedure. This includes water, breath mints, gum, and candies.

Failure to follow these instructions will result in delay or cancellation of your procedure.

**LOCATION AND ARRIVAL TIMES:**

❖ **Raleigh Endoscopy Center Patients:** Please arrive at the endoscopy center ONE HOUR prior to your procedure. \*\* If your procedure time is 7:30am, please arrive at **6:45am**. The endoscopy center opens at 6:45am, please do not arrive any earlier than 6:45am.

\*\*If your physician is Dr. Furs or Dr. McGowan, please arrive one and a half (1 ½) hours prior to your procedure time, but no earlier than 6:45am.

❖ **WakeMed Cary Patients:** Please arrive 2 hours prior to procedure time.

**If you have any questions or need additional information, please contact us at (919) 816-4948.**

## COLONOSCOPY CATEGORIES

The Affordable Care Act allows for preventive services, such as colonoscopies, to be covered at no cost to the patient. However, there are strict guidelines used to determine which category of colonoscopy can be defined as a screening/preventive service. These guidelines may exclude those patients with any current gastrointestinal signs and symptoms, history of gastrointestinal disease, a personal or family history of colon polyps or colon cancer from taking advantage of the procedure at no cost. In cases like these, patients may be required to pay co-pays, co-insurance and/or deductibles.

**Please Note:** Although your primary care provider may refer you for a “screening” colonoscopy, you may not qualify for the “preventive/screening colonoscopy” benefit under your insurance plan. There are three colonoscopy categories:

- **Diagnostic/Therapeutic Colonoscopy** - If you have any gastrointestinal symptoms (i.e diarrhea, constipation, rectal bleeding, abdominal pain, etc.), colon polyps, iron deficiency anemia, gastrointestinal disease or other abnormal tests requiring evaluation or treatment by colonoscopy. Usually subject to copay, coinsurance and/or deductible.
- **Surveillance / High Risk Colonoscopy** - If you are asymptomatic (no current gastrointestinal symptoms) and have a personal history of gastrointestinal disease (such as diverticulitis, Crohn’s disease or ulcerative colitis), and/or a personal or family history of colon polyps and/or colon cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals, usually every 2 - 5 years. May be subject to copay, coinsurance and/or deductible.
- **Screening/Preventive Colonoscopy** - If you are asymptomatic (no current gastrointestinal symptoms), 50 years old or older and have no personal history of gastrointestinal disease, no personal or family history of colon polyps and/or cancer. Patients in this category have not undergone a colonoscopy, or other screening for colon cancer, within the last 10 years. If these guidelines are met, may be covered at 100% under your plan.

## FREQUENTLY ASKED QUESTIONS

### **Q Who will bill me?**

**A** You may receive bills for separate entities associated with your procedure, such as the physician, facility, anesthesia, pathology (both processing and reading) and/or laboratory. The standard of care for anesthesia during your colonoscopy is propofol sedation. The CPT code for this service is 00810.

### **Q Can the provider change, add, or delete my diagnosis so that my procedure can be considered a screening/preventative colonoscopy?**

**A No.** Any visits or history that you provided or your referring physician documented in the medical record is part of a binding legal document that cannot be changed or altered to facilitate better insurance coverage.

### **Q What if my insurance tells me that Cary Gastro can change, add or delete a CPT code or diagnosis code?**

**A** If you are given this information please document the date of the call, name and phone number of the insurance representative to whom you spoke. Then contact the provider’s office and speak to a member of our billing team. Your insurance may tell you if your procedure is coded as a screening it will be covered at 100%. However, if your procedure does not meet the definition of a screening/preventative then it cannot be re-coded and filed as a screening/preventative colonoscopy.

### **Q Will someone call me about what I owe?**

**A** As a courtesy, our office will check with your health insurance plan to obtain a cost estimate and see if a precertification is required. We require deposits on all procedures and you will be asked to provide this either at the time of your office visit or, if we schedule your procedure over the phone, at this time. We can never guarantee how your health insurance will pay for your services. It is always a good idea to call your insurance and understand your benefits and your health insurance expectations.

## COST ESTIMATE WORKSHEET – Please Call Your Insurance Carrier

### HOW WILL I KNOW WHAT I OWE?

- Identify category of colonoscopy you are scheduled for and use possible preoperative CPT and diagnosis codes below. If you need assistance please contact the office for preoperative diagnosis codes on your order. Remember the guidelines above. Your procedure is only “screening” if you have not had a colonoscopy or other screening for colon cancer within the last 10 years. Your scheduling confirmation letter will have both the CPT and diagnostic codes listed for you.
- **Possible CPT Codes:**
  - Diagnostic: 45378, 45380, 45384, 45385**
  - Surveillance: 45378, 45380, 45384, 45385, G0105**
  - Screening/Preventative: G0121, 45378 (only covered with Z12.11 as diagnosis code)**

**Diagnosis(es)** \_\_\_\_\_

Please note that these are not the final diagnosis codes which will be submitted to your insurance. Final codes cannot be determined until after your procedure occurs.

- Call your insurance carrier and verify your benefits and coverage by asking the following questions:  
Is the procedure and diagnosis covered under my policy? Yes No

Will the diagnosis code be processed as: preventive (screening) surveillance or diagnostic?

If my procedure will be a preventive (screening) procedure, are there age or frequency limitations for my colonoscopy? (e.g., one SCREENING every ten years over the age of 50)  
Yes No

If YES, list limitations here  
\_\_\_\_\_

If the provider removes a polyp or takes a biopsy, will this change my out-of-pocket responsibility? Yes No

#### OBTAIN THE FOLLOWING INFORMATION FROM YOUR INSURANCE REPRESENTATIVE:

Today's Date \_\_\_\_\_ Representative's Name \_\_\_\_\_

Deductible \_\_\_\_\_ Amount of Deductible Met \_\_\_\_\_

Co-insurance Responsibility \_\_\_\_\_ Facility Co-payment \_\_\_\_\_

Facility in Network Yes No

Call Reference Number \_\_\_\_\_

If you have any questions, concerns, or would like to discuss payment arrangements, please contact the billing department at our office.



## Frequently Asked Questions

### [Just had your procedure? Now what?](#)

Ideally, your insurance will process everything correctly the first time around so you won't need to worry about anything. In the unfortunate case that they do not, we will send a letter with a statement and a form to sign so that we can assist in getting your balance reduced or eliminated.

### [Do I need to file anything with my insurance provider?](#)

As a courtesy to you, the bills for your anesthesia services will be filed to your insurance company. We have accepted assignment of these benefits and your insurance company should send the payment directly to our office. If we have a secondary insurance on file for you, we will file a claim for the amount not paid by your primary insurance. If there is no secondary insurance on file, then we will send you a bill for the co-payment due as determined by your insurance company.

### [My insurance sent me a check, what should I do?](#)

If your insurance company sends payment directly to you, you may either endorse the check **OR** write a personal check for the amount received and send it to the address listed below.

Raleigh Sedation Associates  
P O Box 865619  
Orlando, FL 32886-5619

### [What insurance providers do you participate with?](#)

We accept any insurance that the facility where you are having the service accepts. Because we are an ancillary provider, we typically do not need to contract separately with your insurance to be processed in-network (several BCBS plans are the exception). We contract with all federal (Medicare, Tricare) and state plans (Medicaid).

In the event that we are not a participating anesthesia provider within your insurance plan, we will work with your insurance company to insure that **you are not penalized** for our non-participating (out-of-network) status. The maximum amount that you will owe will be your participating (in-network) benefit rates. Please contact us if you have **ANY** concerns.

### [What if my insurance provider participates with the endoscopy center but not with RSA?](#)

We accept any insurance that the center accepts. Anesthesia providers are considered ancillary providers and because of this, regardless of our network status, most insurances will process the claim as though we are in network. Plan types typically have a plan provision that states ancillary providers (such as radiologists, anesthesiologists and pathologists) will be processed under your in-network level of benefits as long as the facility is in-network. We work directly with your insurance regarding the amount and will not hold patients responsible for any out of network or pricing differences. On occasion, the insurances do not process payments correctly the first time around so we may need your assistance by signing a form in order to reduce or eliminate your responsibility. We will contact you if this is necessary.

### [How to read your patient statement](#)

#### Column 1: Dates

The first line item will be the date of service. All other line items will be the date a payment or adjustment was taken.

#### Column 2: Description of service

This is where you see the service billed for, the provider who performed the service, and any information regarding payments and adjustments.

#### Column 3: Financial amounts

These are the costs for what is described in column 2.

## Columns 4 & 5: Balances

These are any balances on your account to be paid by your insurance (Column 4) or you (Column 5).

We advise you to pay close attention to the message at the bottom of the statement. This message often provides important information such as to whether the balance can be further reduced, or what to do in the case you receive a check from your insurance provider that needs to be forwarded so that an adjustment can be made.

### [How to read your Explanation of Benefits \(EOB\)](#)

Your EOB is plan specific, so please contact us directly so that we can address your specific questions over the phone. If we are notified of a denial, we will send you notices explaining your benefits and appeal rights. These letters are insurance specific and typically explain what needs to be done to have the balance reduced or eliminated.

#### *Your EOB may identify:*

- The patient and the service provided
- The amount charged by the provider
- The amount of the charges that are covered and not covered under your plan
- The amount paid to your provider
- The amount you're responsible for

Remember that your EOB is not a bill, it just explains what was covered by insurance. Your provider may bill you separately for any charges you're still responsible for. You may receive a few EOB's over time if your claim is being appealed.

### [How much does anesthesia cost?](#)

Providing an estimate is quite difficult for anesthesia because processing is based on time or charged amount and is plan specific. If your service is a screening procedure, most plans will cover this at 100% of their allowed amount. Exceptions to this include some BCBS plans and grandfathered commercial plans. We are happy to assist when possible, however, due to the number of insurance plans, we suggest that you contact your insurance company if you have specific question regarding your individual coverage. If you are not covered by your insurance and required information regarding self-pay rates, please contact us.

### [Why did I receive multiple bills for the same procedure?](#)

The procedure you had has 3 (three), possibly 4 (four) separately billable components that consist of:

1. The professional services of the gastroenterologist
2. **The professional & medical services of the anesthesiologist / anesthetist**
3. The facility fee (for use of the surgery center)
4. Pathology/lab fees (if you have polyps removed or biopsies taken)

Each of these services is provided under separate entities/companies and cannot answer billing questions for the other, so please contact the appropriate company for your questions. We can address all questions related to #2.

### [When is payment due?](#)

Payment is due within 10 days of receipt of the statement, however we do accept payments in installments. If you would like to pay in installments, please notify us by contacting us directly.

### [What forms of payment do you accept?](#)

We accept credit cards and checks. You can pay online using our payment portal.

If you would prefer to pay over the phone, please contact us at **1-888-337-3509** or **1-919-324-1680**.

Alternatively, you can mail a check to:

Raleigh Sedation Associates  
P O Box 865619  
Orlando, FL 32886-5619