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 ENDOSCOPI START OF DOCUMENT INCORRECTLY

Allergies: Medication and Food Allergies(Please List Below): Include any allergy to eggs or soy
Name of medication/Food  Reaction to Medication/Food
1._____________________________________   ____________________________________________________
2._____________________________________   ____________________________________________________
3._____________________________________   ____________________________________________________

MEDICATIONS: LIST ALL (BOTH PRESCRIPTION & NON PRESCRIPTION, ALSO ALL SUPPLEMENTS & VITAMINS):
MEDICATION NAME        DOSE TAKEN     FREQUENCY     REASON TAKEN
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 Breath?           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.__________________________________________________
Coding Your Procedure

Your procedure will be coded based upon documentation from your physician during the procedure, which may not be covered by your insurance carrier at 100%. If abnormal findings such as a polyp or lesion are detected and removed, the service may then be considered diagnostic by your insurance carrier. Please be aware that you will be responsible for any expenses not covered by your insurance carrier and that the diagnosis code will not be changed in an attempt to reduce out of pocket expenses.

Deposits for procedures and/or pathology will be required. Deposits are nonrefundable for procedures not cancelled per cancellation policy, and will be applied towards any out of pocket expenses. Questions regarding specific portions of your bill can be addressed as follows:

<table>
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<tr>
<th></th>
<th>Cary Gastroenterology</th>
<th>(919) 816-4948</th>
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<tbody>
<tr>
<td>Physician</td>
<td>Raleigh Endoscopy Center</td>
<td>(844) 248-1741</td>
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<tr>
<td>Facility fees</td>
<td>Raleigh Sedation Services</td>
<td>(919) 324-1680/(888) 337-3509</td>
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Cancelation Policy

Cancelling Your Procedure – You must provide at least 3 business days notice to cancel your procedure. Procedures that are not cancelled with proper notice will be charged a cancellation fee of $100.00. Deposits for procedures that are not cancelled per this policy are nonrefundable.

No Shows – Procedures - Failure to show for a procedure without a cancellation call to us will result in a “No Show” charge of $100.00. Deposits for procedures that are “no showed” per this policy are nonrefundable.

Notice of Patient Rights

Cary Gastroenterology provides Notice of Patient Rights to you for both Cary Gastroenterology and Raleigh Endoscopy Centers. These documents can be located at www.carygastro.com; Procedures; Paperwork; Notice of Patient Rights.
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 propofal 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, one every two years for a personal history of polyps beginning at age 45, etc.) 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:

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<tr>
<th>Today’s Date</th>
<th>Representative’s Name</th>
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<th>Deductible</th>
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<tr>
<th>Co-insurance Responsibility</th>
<th>Facility Co-payment</th>
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<tr>
<th>Facility in Network</th>
<th>Yes</th>
<th>No</th>
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If you have any questions, concerns, or would like to discuss payment arrangements, please contact the billing department at our office.