Gastrointestinal Medicine Associates, P.C.

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COLORECTAL CANCER SCREENING AND/OR EGD OPEN ACCESS PACKET

After careful medical assessment, your healthcare provider has recommended that you have a colonoscopy and/or upper endoscopy. Colon cancer is the second leading cause of cancer death in the United States, and a colonoscopy is the recommended screening test for any patient age 50 or older. For those with a family history of colon cancer, a colonoscopy is recommended 10 years before the family member's age at diagnosis. This webpage and downloadable packet are designed to efficiently guide you through the scheduling process for your Open Access procedure without requiring an office visit.

You are invited to proceed with an Open Access procedure if you meet the following criteria:

- ✓ Colonoscopy is for routine screening, history of polyps/colon cancer, a family history of colon neoplasm, or routine colonoscopy for inflammatory bowel disease in remission
- ✓ If an EGD is required for bariatric surgery/Barrett's Esophagus
- ✓ You have NO active symptoms (abdominal pain, a change in bowel habits, etc.)
- ✓ You do NOT have severe lung or heart disease

If you believe that Open Access is the right option for you, please print/complete this packet. You may send the packet (with required ID's) to our office via mail, email, or fax. Please allow up to two weeks for our office to review your packet and pre-certify your exam. If you require immediate scheduling for any reason, please call our office at 703-281-1023. After our Advanced Practitioners reviews your paperwork, we reserve the right to require an office visit prior to proceeding with your procedure. If that is the case, our scheduling staff will inform you of the reason for your office visit when they call. Once your paperwork is cleared by our Advanced Practitioners, we will notify you to schedule your procedure. If you have not heard from our office within two weeks, please call us at 703-281-1023.

When your procedure is scheduled, we will email you a packet with your date/time, facility information and instructions. Your bowel preparation (if required) will be sent electronically to your local pharmacy.

If you do not meet the criteria for Open Access, please call the office at 703-281-1023, and speak to a receptionist to schedule an appointment.

You may submit your forms in one of three ways:

Mail: Gastrointestinal Medicine Associates
3620 Joseph Siewick Drive Suite 307 Fairfax, VA 22033 *ATTN: Open Access*
Fax: 703-890-3109
Email: openaccess@gastromedva.onmicrosoft.com

Your procedure must be scheduled within 30 days of submitting your paperwork.

We will check with your insurance if a pre-authorization is required, after you are scheduled, but we will not know what/if the procedure is covered cost wise. You can contact your insurance and give them the following CPT codes to discuss cost.

Colonoscopy (Screening) 45378 *EGD 43235*
Colonoscopy (w/ Biopsy) 45380 *EGD (w/ Biopsy) 43239*

If you have any questions or concerns regarding this procedure, please call the office at 703-281-1023 and ask for the Open Access Coordinator.

We look forward to working with you!

Gastrointestinal Medicine Associates, P.C.

Open Access Colonoscopy and EGD Cover Sheet

Patient Name: _____ Date of Birth: _____

Number of pages including this cover sheet: _____

Check List

- ☐ Coversheet/Checklist
- ☐ Patient Demographics
- ☐ Authorization and Consent to Treatment/Consent to Call/Preferred Method of Communication
- ☐ Acknowledgement of Office Policies
- ☐ Completed Medicare Consent (if req.)
- ☐ Past Medical History Forms (2 pages)
- ☐ Procedure Scheduling Consent
- ☐ Procedure Consent
- ☐ **Photo ID**
- ☐ **Insurance Card (front and back)**

*****All required forms must be completed, signed and dated when sent to GMA. If any form is incomplete or missing, or you do not have copies of your insurance cards and photo ID attached, your packet will be returned to you for completion.**

IF A REFERRAL IS REQUIRED BY YOUR INSURANCE, YOU MUST SUBMIT IT WITH THIS PACKET! YOU CANNOT BE SCHEDULED WITHOUT IT.

Please read all instructions and information contained in the packet thoroughly.

You will receive your bowel preparations instructions (if required) once you are scheduled.

All the information contained in this packet is complete and true to my knowledge.

_____ _____

Patient Signature **Date**

PLEASE MARK WHICH PROCEDURE YOU ARE INTERESTED IN SCHEDULING:

COLONOSCOPY ☐ **UPPER ENDOSCOPY(EGD) ☐** **BOTH (EGD & COLON) ☐**

OFFICE USE ONLY:

Gastrointestinal Medicine Associates, P.C.

PATIENT DEMOGRAPHIC INFORMATION

Patient Full Name: _____ Date of Birth: _____

Age: _____ Male/Female

Address: _____

City: _____ State: _____ Zip code: _____

Home # _____ Preferred Contact: Home □ Cell □ Work □

Cell # _____ Marital Status: S / M / D / W

Work # _____ Social Security # _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Primary Care Physician: _____ City: _____

Cardiologist: _____ City: _____

Preferred Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name: _____ ID #: _____

Policy Holder Name (if not the patient): _____

Policy Holder DOB (if not the patient): _____ Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____ ID #: _____

Policy Holder Name (if not the patient): _____

Policy Holder DOB (if not the patient): _____ Relationship to Patient: _____

PLEASE ATTACH A FRONT AND BACK COPY OF YOUR ID AND INSURANCE CARD(S) TO THE BACK OF THIS PACKET. PACKETS SUBMITTED WITHOUT CARE COPIES WILL NOT BE PROCESSED.

Gastrointestinal Medicine Associates, P.C.

Authorization and Consent to Treatment

As a GMA patient, I voluntarily consent to the rendering of such care and treatment as the GMA providers and personnel, in their professional judgement, deem necessary for my health and well-being. My consent shall include, but not limited to, medical examination and diagnostic testing. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my GMA provider nor any care center staff has made and guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that GMA may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from GMA.I understand that I may voluntarily "opt-in" to receive automated text message communications from GMA by informing GMA staff or visiting my Athena Patient Portal and agreeing to any additional Terms and Conditions established by my mobile carrier.

Preferred Method of Communication

You have the right to direct how and where GMA communicates with you. Please let us know your preferred method of communication. You may update or change this information at any time; please do so in writing.
I prefer to be contacted in the following manner (check all that apply):

- ☐ Home Tele.: _____
  - ○ OK to leave message with detailed information
  - ○ Leave message with call-back number only
- ☐ Cell Phone: _____
  - ○ OK to leave message with detailed information
  - ○ Leave message with call-back number only
- ☐ Patient Portal
- ☐ Written Communication
  - ○ Please send all my mail to my home address on file
  - ○ Please send all mail to THIS address: _____

I authorize GMA that family members may have access to my records or to act on my behalf in the coordination of my care. **(Please Circle One)**

YES NO

If yes, only those family members listed below may have access to my records.

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

_____ _____
Signature of Patient / Legal Representative Date

_____ _____
Printed Name Date of Birth

Gastrointestinal Medicine Associates, P.C.

ACKNOWLEDGEMENT AND AUTHORIZATION OF GMA OFFICE POLICIES:

Policies can be found on our website.
Please sign and date each point. Any questions can be answered by our receptionists.

- **I have read and understand the HIPAA/Privacy Policy for Gastrointestinal Medicine Associates, P.C.**

Patient Initials _____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Patient Initials _____

- **I authorize Gastrointestinal Medicine Associates, P.C. to release medical information required to process my claim**

Patient Initials _____

- **I have read and understand the Financial Policy for Gastrointestinal Medicine Associates, P.C.**

Patient Initials _____

- **I authorize Gastrointestinal Medicine Associates, P.C.to obtain/have access to my medication history**

Patient Initials _____

- **I authorize my provider's office to contact me by mobile phone**

Patient Initials _____

_____ _____

Patient Signature **Date of Signature**

_____ _____

Patients Name (Printed) **Patients Date of Birth**

Gastrointestinal Medicine Associates, P.C.

Medicare Statement

This form should only be signed by patients who are *NOT* currently enrolled/applied for in any/all Medicare plans. <u>If you have a Medicare plan please disregard this form.</u>

I attest that I ***DO NOT*** have any Medicare Insurance (including but not limited to the following):

- Medicare Part A & B
- Medicare Part A only
- Medicare Part B only
- Medicare as Secondary
- Medicare eligible and applied for pending approval

I understand that if I have any part of Medicare, I am unable to have my outpatient procedure at the Gastroenterology Center of Virginia.
(This facility is non-participating with <u>all</u> Medicare Plans)

<u>Procedure Location:</u> The Gastroenterology Center of Virginia
11440 Commerce Park Drive Suite LL4
Reston, VA 20191 (703) 776-2600

_____ _____
Printed Name Date of Birth

_____ _____
Patient Signature Todays Date

_____ _____
Witness Signature Todays Date

Gastrointestinal Medicine Associates, P.C.

PATIENT MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Medication Allergies: _____ **Height:** _____**Weight:** _____

LAST PHYSICAL: _____ **Normal** ☐ **Abnormal** ☐
LAST EKG: _____ **Normal** ☐ **Abnormal** ☐

1. **Please indicate whether you are having any of the following symptoms:**

☐ Abdominal Pain
☐ Change in bowel habits
☐ Diarrhea
☐ Constipation
☐ Rectal bleeding
☐ Loss of appetite
☐ Unintentional weight loss (amount) _____
☐ Gout
☐ Heartburn/reflux
☐ Difficulty Swallowing/Food gets stuck
☐ NONE OF THE ABOVE

2. **Personal Medical History (Please check all that apply)**

☐ Hypertension/High Blood Pressure
☐ CAD
☐ Atrial fibrillation
☐ Seizures
☐ Diabetes
☐ Renal/Kidney Disease
☐ MRSA
☐ Sleep apnea or CPAP use
☐ Asthma/COPD
☐ Blood disorder/Cancer Type: _____
☐ Other: _____
☐ NONE OF THE ABOVE

3. **Current Medications: (Please list all prescription and over the counter medications or attach a copy to this packet) <u>Blood thinners are of importance.</u>**

Medication name	Dosage
• _____	_____
• _____	_____
• _____	_____
• _____	_____

4. **Social History**

☐ Tobacco History How much? _____
☐ Alcohol How much? _____
☐ Caffeine How much? _____
☐ Exercise Routine What/quantity? _____

5. **Family History (Please check all that apply and indicate family member & age of diagnosis)**

☐ Colon Cancer _____ ☐ Colon Polyps _____
☐ Stomach Cancer _____ ☐ Esophageal Cancer _____
☐ Barrett's Esophagus _____ ☐ Peptic Ulcer Disease _____
☐ Crohn's Disease _____ ☐ Ulcerative Colitis _____
☐ Gallbladder Disease _____ ☐ Breast or GYN Cancer _____

6. **Procedure History (When was your last procedure and what were the results?)**
☐ Colonoscopy ____/____/____ ☐ Normal ☐ Polyps or other _____
☐ Upper Endoscopy (EGD) ____/____/____ ☐ Normal ☐ Other _____
☐ Flexible Sigmoidoscopy ____/____/____ ☐ Normal ☐ Other_____
☐ I have never had and endoscopies

7. **Surgical History or Hospitalizations (or attach a copy to this packet)**
☐ NONE
_____/_____/_____ _____
_____/_____/_____ _____
_____/_____/_____ _____
_____/_____/_____ _____
☐ Personal or Family History of Problems with Anesthesia
_____

The medical information provided in this packet is complete and true to my knowledge.

_____ _____
Patient Signature **Date**

FOR OFFICE USE ONLY

1. **BMI: _____ SLEEP APNEA: YES ☐ NO ☐**
2. **Patient scheduled for procedure? ☐ YES ☐ NO**
3. **Reason: ☐ CRCS ☐ FHx ☐ H/O Polyps ☐ H/O Cancer ☐ Other _____**
4. **☐ Suprep ☐ Clenpiq ☐ Moviprep ☐ Plenvu ☐ Trilyte ☐ Other _____**
5. **☐ GCV ☐ ASC ☐ FOH ☐ ILH ☐ RHC**
6. **☐ RAB ☐ SSH ☐ HSS**
7. **Patient needs office visit for: _____**

MLP Signature _____ Date _____

Gastrointestinal Medicine Associates, P.C.

PROCEDURE SCHEDULING FORM

PLEASE READ THIS FORM CAREFULLY AMD COMPLETE ALL SECTIONS

If you need to schedule, reschedule or cancel any procedures please call us at 703-281-1023 and press the option for the procedure coordinator. Please **DO NOT** call the facility or leave messages concerning procedure scheduling on the nurses' voicemail. Your call will be returned by our coordinator within 48 hours.

Are you an insulin-dependent diabetic? (If yes, A.M. appointments only): | □ YES | ☐ NO

I give my permission for procedure appointment information *(not results)* **to be left:**

(May check more than one)

☐ Left on home answering machine
☐ Left on cell phone voicemail
Cell phone # _____
☐ Left with spouse/immediate family
☐ Left on work voicemail
☐ Left with assistant

- Due to unavoidable circumstances, the time of my procedure is subject to change due to cancellation and/or emergencies. I understand this is infrequent but may happen. If a change in my procedure time is necessary, I will be notified immediately.
- I understand that I must notify Gastrointestinal Medicine Associates, P.C. at 703-281-1023 ext. 105 if I wish to cancel my procedure for any non-emergency reason or if my insurance has changed. If I fail to do this within **FIVE (5) BUSINESS DAYS** of my scheduled time I will be charged **$250.00**. I understand that if I call to reschedule within **TWO (2) BUSINESS DAYS** of my procedure I will be charged **$100.00**.
- **I understand that work is not an emergency.**
- I understand that I cannot drive myself home following my procedure, and that I must be accompanied by someone who will be responsible for taking me home. The use of a taxi or public transportation to go home following my procedure is unacceptable unless I am accompanied by an adult.
- I understand that I will be responsible for all cost associated with my procedure and that **I may receive bills from the facility, the doctor, anesthesia and pathology**.
- I understand that I can call my insurance for coverage information and my out of pocket costs.

**** Patients who are scheduled for screening examinations, who have no signs or symptoms, have a set benefit from their insurance company. You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change, and your insurance policy will pay differently.**

By signing this form, I have read and agree to all the above information.
I understand I cannot be scheduled if I do not sign this form.

Due to insurance and healthcare liabilities, I understand that I will have to resubmit my Open Access Packet if I do not complete my procedure within 30 days from the date printed.

_____ **Print Patient Name**

_____ **Witness (Staff)**

_____ **Signature (Patient or Legal Guardian)**

_____ **Date**

Gastrointestinal Medicine Associates, P.C.

EGD / COLONOSCOPY INFORMATION AND CONSENT

An **upper endoscopy (EGD)** is an examination which enables direct inspection of the esophagus, stomach, and duodenum. There are no x-rays involved with this procedure. A flexible gastroscope (a tube containing light, lens, and biopsy channel) is used for this procedure through which biopsies can be obtained. Neither the Endoscopy nor the biopsy is associated with any pain.

A **Colonoscopy** is an endoscopic examination of the colon. This procedure is usually done as outpatient and involves the insertion of a flexible scope instrument into the rectum and the entire colon. Colonoscopy may be only diagnostic, or it may be therapeutic, in which case a polyp may be removed, or a biopsy may be taken, or a bleed site cauterized using an electrical current.

PREPARATION: Please **discontinue** iron **one week** prior to your procedure date. **Please hold** blood thinners as directed in your pre-procedure consultation. Please **continue** all other medications until the day before your procedure. (Please consult with your doctor concerning any medication taken in the morning, especially insulin, blood pressure, seizure, ore cardiac medications, as they may be allowed.) Please follow the preparation instructions given to you for the day before – for EGD's this means nothing to eat or drink after midnight.

SEDATION: Preoperative medications include an intravenous injection of sedation medication (LMAC) administered by an anesthesiologist to ensure the patient is relaxed and comfortable. *General anesthesia* is not required. Because of the sedation, the patient WILL NOT be allowed to drive him or herself home. Transportation home must be arranged with another person and not by taxi, Uber or Lyft (unless accompanied by an adult.)

RISKS: There are a few risks related to the EGD. Risks of bleeding, perforation, and aspiration of gastric contents into the lung are exceedingly rare, but are somewhat more common in elderly patients, and in individuals who have had multiple abdominal operations, a history of abdominal infections, or prior radiation therapy. Serious complications of a colonoscopy such as intestinal bleeding and/or perforation are relatively infrequent and depend on whether the examination is diagnostic or therapeutic. The other significant risks include side effects from medication, such as over sedation or severe allergic reactions, and possible irritation of the vein at the IV site called phlebitis.

Risks of Colonoscopy	Diagnostic	Therapeutic
Bleeding	Less than 1%	1.5-2%
Perforation	Less than 1%	Less than 1%

RESULTS: Results will be uploaded to your patient portal within 3-4 weeks. We will provide you with the results of your procedure via patient portal or by arranging an office visit for follow-up. If you do not have a portal, please call the office at 703-281-1023 and request a mailed copy from the results line 3-4 weeks after your procedure. *If any serious abnormality is identified, you will receive a phone call as soon as possible.* **(Please do not call the office for results by phone.)**

CONSENT: I have read the above information and understand the indications for an

☐ EGD ☐ COLONOSCOPY ☐ OTHER _____,

its potential benefits, and potential complications. I consent to the taking and reproduction of any photographs of the procedure for professional purposes. **I hereby authorize and permit Dr. _____** and whoever he may designate as his assistant, to perform my procedure.

Preparation instructions and facility information will be sent via email once you are scheduled. Prescriptions will be sent to the pharmacy in your file.

_____ _____

Print Patient Name **Witness (Staff)**

_____ _____

Signature (Patient, or legal guardian) **Date**