ROCKWALL SURGICAL SPECIALISTS

1005 W. RALPH HALL PKWY, STE. 211, ROCKWALL, TX 75032

PHONE: 972-412-7700 FAX: 972-412-7710

DAVID RITTER, MD *ASHLEY EGAN, MD* *JON HARRIS, MD* *JOSHUA MARK, MD*

COLONOSCOPY SCREENING

We have received a request asking us to schedule your Screening Colonoscopy.

If you are **NOT** experiencing any problems and only need a Screening Colonoscopy, you do NOT need an office visit prior to the procedure.

Attached you will find the following forms:

1. Patient Information Forms
2. Colonoscopy Bowel Prep Instructions and Prescription
3. Colonoscopy Information Form

When you are ready to schedule, please complete the attached forms and return to our office along with a legible copy of your driver's license and insurance card FRONT and BACK. ****WE MUST HAVE A COPY OF DL AND INSURANCE CARD (LEGIBLE) PRIOR TO SCHEDULING****

PLEASE KEEP THE FOLLOWING FORMS TO REVIEW WITH THE SCHEDULER WHEN SHE CALLS YOU AFTER VERIFYING YOUR INSRANCE BENEFITS:

1. Colonoscopy Bowel Prep Instructions with attached prescription
2. Blank Colonoscopy Information Form
3. **MAIL THE NEW PATIENT INFORMATION FORMS TO THE ADDRESS ABOVE (ATTN:Ann).**

Once we have received ALL requested, completed information, we will verify your insurance benefits and our Colonoscopy Scheduler will be contacting you to schedule your procedure.

If you **ARE** having any problems and need an appointment, please call the office phone number listed above for an office visit.

Thank you!

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PATIENT REGISTRATION FORM

_____ _____ _____
Patient's name (Last, First, Middle Initial) Sex (M or F) Date of Birth

_____
Address

_____ _____ _____
City State Zip

_____ _____ _____
Home Phone Cell Phone Email

May we leave a detailed message: Yes or No If so, where: Home or Cell May we email you: Yes or No

_____ _____ _____
Marital Status Social Security Number Driver's License Number

_____ _____ _____
Race Ethnicity Preferred Language Spoken

_____ _____ _____
Emergency Contact Name Relationship Phone number

_____ _____ Is this Worker's Comp? YES NO
Employer's Name Employer's Phone Number

_____
Employer's Address City State Zip

What is your occupation? _____ How long? _____

_____ _____
1.) Name of Insurance Company ID Number

_____ _____ _____
Policy Holder's Name DOB for Policy Holder Relationship to Patient

_____ _____
Policy Holder's Employer Phone Number

_____ _____
2.) Name of Secondary Insurance Company ID Number

_____ _____ _____
Policy Holder's Name DOB for Policy Holder Relationship to Patient

_____ _____
Policy Holder's Employer Phone Number

Signature:_____ ***Date:_____***

PATIENT MEDICAL HISTORY/INFORMATION

Name: _____ **DOB:** _____

PCP/referring provider: _____ **Chief complaint:**_____

Do you have a history of:

___High Blood Pressure ___Heart disease ___Hepatitis ___Blood clots
___Cancer ___Breast disease ___HIV/AIDS ___Pulmonary embolism
___Diabetes ___High cholesterol ___Blood transfusion ___Sleep apnea
____Other: Please specify _____

Family History (Please list): _____

Please List ALL of your previous surgeries:

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

Last colonoscopy? _____ **Last EGD? _____**

Please list ALL current medications, dose, amt/day:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Do you take any blood thinners (such as Coumadin, Plavix, Xarelto, Aspirin, etc...):_____

Please list your drug allergies: _____

Pharmacy Preference: _____

Location/Town: _____ Phone number: _____

Do you:

___ Smoke? How long? _____ ___Have you ever smoked? How long? _____
___ Drink alcohol? How much? _____ ___Do drugs? What? _____
___ Diet pills? What kind? _____

Have you recently had any of the following?

___Nausea/Vomiting ___Weight loss ___Weight gain ___ Chest pain
___Fever/Chills ___Seizure ___Change in appetite ___Heart palpitations
___Weakness ___Double vision ___Abdominal pain ___Heart murmur
___Bleeding problems ___Vision changes ___Blood in stool ___Leg swelling
___Swollen glands ___Earache ___Constipation ___Edema
___ Difficulty swallowing ___Headache ___Hemorrhoids ___Nipple discharge
___Acid reflux/heart burn ___Nose Bleeds ___Abdominal mass ___Breast lump
___Depression ___Hearing loss ___Blood in urine ___Rash
___Painful joints ___Itching ___Painful urination ___Change in mole
___Neck pain ___Hay fever ___Shortness of breath ___ Immune problems
___Jaundice ___Pneumonia ___Asthma ___ Allergy to iodine

Sign: _____ **Date: _____**

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES AT FUTURE VISITS.

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HIPAA PATIENT ACKNOWLEDGMENT FORM

In signing this HIPAA Patient Acknowledgment form, I acknowledge and authorize, that I hold harmless this Healthcare Facility, its employees, and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state laws has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Rockwall Surgical Specialists must have my consent, therefore, I authorize Rockwall Surgical Specialists to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (Check all that apply):

___All procedures ____Test results ____Appointments ____Other ___Surgeries ___Billing/Account information

Name(s) of the person(s) authorized to obtain the abovementioned information. (e.g. Physician other than your referring doctor, family members and other specified person(s))

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorize Rockwall Surgical Specialists to contact me at the with results or questions and acknowledge if I chose to have my information emailed there is a risk of breach.

Patient name: (Print and Sign) _____

Date: _____

Patient representative: (Print name and sign) _____

Relationship to patient:_____

Date: _____

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ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, Dr. Joshua Mark, and staff to render consultation and treatment. I understand that if I am a minor, a parent or legal guardian must be present at the time of consultation. I, the undersigned, certify that I or my dependent, have insurance coverage and that I have provided that information. I also understand that it is MY RESPONSIBILITY to keep the information updated. I understand there is the possibility that Out-of-Network Provider(s) may provide all or part of the Covered Services. You may contact your insurance company for more information. I assign directly to the above-mentioned physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for all procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collections and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collections. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In the course of your treatment from Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark, you may be referred to, or certain procedures may be performed at a facility that the physician may have a financial interest in. By signing this disclosure, you acknowledge the physician's possible financial interest in this facility and your election to use such facility. You are not required to use any of these facilities and have the option to use an alternative health care facility. Please let us know if you have any concerns regarding the relationship between the physician and facilities.

We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark the fees that are quoted to you from this office are for the services rendered by our office only. You will need to discuss laboratory, pathology, anesthesiology, and facility charges with those individuals. They each have a separate billing office and have NO AFFILIATION with our office. The amount you are requested to pay at the time of scheduling is an estimated amount, due to your insurance benefits. After the surgical procedure or medical services are preformed, your insurance company will be billed. If there is any remaining balance that you are required to pay, you will receive a statement from our office with that amount on it. By signing this form, you acknowledge that you are responsible for any balances on your account and or any services not covered by your insurance company. I have read the above statement and agree that if my insurance company fails to pay, I accept responsibility for charges incurred.

I have read and understand the above disclosure.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____ DATE: _____

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FMLA/Short Term Disability Release of Information Authorization

I, _____, here by authorize Rockwall Surgical Specialists (physicians and staff) to release any information requested from my employer, human resource department, insurance company, or disability company that is in regard to my time off work request, family leave forms (FMLA), disability payments, or time off compensation.

I also understand that at any time I can revoke this authorization by submitting a request in writing. If I need to re-instate this authorization, I must sign a new form with a current date and this request must be presented in person (by the patient) for authenticity.

_____

Printed name

_____

Signature

_____

Date

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ROUTINE COLONOSCOPY SCREENING

The majority of insurance companies cover one Routine Colonoscopy Screening every 10 years after the age of 50 under your preventative benefits at 100%.

Rules differ depending on each insurance company and/or group insurance plan. However, it is important to note that, if while performing your Routine Colonoscopy, the physician finds and removes colon polyps, your insurance company has the right to apply this procedure to your surgical benefit versus routine benefit.

We do not change the procedure code or bill the insurance company any differently, however, by law, we have to report that polyps were removed. This may affect how your claim is paid by insurance. Again, all insurance companies and plans have different protocols and this may or may not apply to your particular plan. However, we do want to inform you of possible issues prior to your procedure.

As a courtesy to our patients, we will check your benefits and then forward the information to you as we have received it from the customer service representative at your insurance company.

I have read and understand the above information.

_____ _____

Patient name Date

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BAYLOR, SCOTT, & WHITE SURGICARE OF ROCKWALL
825 W. YELLOWJACKET LN.
ROCKWALL, TX 75087
972-772-6166

TEXAS HEALTH SURGERY CENTER OF ROCKWALL
3144 HORIZON RD.
ROCKWALL, TX 75032
972-845-1469

TEXAS HEALTH PRESBYTERIAN HOSPITAL OF ROCKWALL
3150 HORIZON RD.
ROCKWALL, TX 75032
469-698-1000

Colonoscopy Information

PRE OP: via phone

SURGERY DATE: _____

APPROX. CHECK IN:_____ **APPROX. PROCEDURE TIME**: _____

Due to unexpected emergencies, your arrival/procedure time may change. We will make every attempt to contact you; however, it is recommended that you confirm your times with the facility the day prior to your surgery/procedure. Thank you!

*** A NURSE will contact you from the facility no later than the day prior to the procedure to review the information below, medical history, and medications. ****

INSTRUCTIONS:

- **5 DAYS PRIOR TO SURGERY:** NO ANTI-INFLAMMATORIES OR BLOOD THINNERS (Aspirin, Plavix, Coumadin, etc.) Tylenol is okay to take for general pain.
- **You will *NOT* be allowed to drive home following surgery.** Please make arrangements for a driver. Taxi's or any other form of public transportation is not sufficient unless it is a licensed medical transport.
- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT PRIOR TO SURGERY.** If you regularly take blood pressure medicine every morning, then it is OK with a small sip of water.
- **CLEAR LIQUID DIET THE DAY PRIOR AND TAKE THE SUTAB KIT DOSES AT 5:00PM AND 10:00PM.**

*Based on the info we received from your insurance, we may collect a down payment prior to surgery. We will bill you if there is any remaining balance. **THE FACILITY, ANESTHESIOLOGIST, ETC. BILL SEPERATELY AND ARE NOT AFFILIATED WITH ROCKWALL SURGICAL SPECIALISTS.** An insurance specialist from the facility will check you benefits and contact you regarding out of pocket expenses for their facility prior to surgery/procedure.*

SUTAB BOWEL PREP

INSTRUCTIONS FOR THE DAY PRIOR TO YOUR COLONOSCOPY

Stay on a CLEAR LIQUID DIET ALL DAY.

Clear liquids include:

Water, chicken broth, Gatorade, coffee (no creamer), tea, lemonade, limeade, apple juice, WHITE grape juice, clear soft drinks, Jell-O, popsicles.

DO NOT HAVE MILK PRODUCTS, ANYTHING COLORED RED OR PURPLE.

THE EVENING PRIOR @ 5:00PM

Complete steps 1 through 4 using one bottle in your SUTAB kit.

1. Open 1 bottle of 12 tablets.
2. Fill the provided container with 16 ounces of water (up to the fill line). Swallow each tablet with a sip of water and drink the entire amount of water over 15-20 minutes.
3. Approximately 1 hour after the last tablet is ingested, fill the provided container again with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.
4. Approximately 30 minutes after finishing the second container of water, fill the provided container with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

REPEAT ABOVE STEPS @ 10:00PM

Repeat steps 1 through 4 using the other bottle of SUTAB.

Be sure to finish ALL the SUTAB TABLETS and water.

Both bottles are required for a complete prep.

GO TO WWW.SUTAB.COM TO PRINT OUT A COUPON FOR YOUR PRESCRIPTION. YOU MAY ALSO PROVIDE THE COUPON TO YOUR PHARMACIST VIA YOUR CELL PHONE IF YOU ARE UNABLE TO PRINT. PATIENTS WITH BCBS, UHC, CIGNA, AETNA, PHCS, ETC WILL RECEIVE THE PRESCRIPTION FOR $40 WITH THIS COUPON. SELF PAY PATIENTS WILL RECEIVE THE PRESCRIPTION FOR $75 WITH THIS COUPON. YOU MUST TAKE THIS COUPON TO THE PHARMACY TO RECEIVE THE DISCOUNT.

STOP!!!!!

All blood thinners **5 (five) days** prior to your surgery. Blood thinners may include:

Aggrenox
Aleve
Arixtra
Aspirin
Brilinta
Celebrex
Cilostazol
Clopidogrel
Coumadin
Dipyridamole
Effient
Eliquis
Excedrin
Fish Oil
Fragmin
Ibuprofen
Naproxen
Mobic
Motrin
Plavix
Pradaxa
Prasugrel
Vitamin E
Xarelto
Warfarin

Tylenol is OK to use if needed

OFFICE LOCATIONS

PLEASE NOTE WE HAVE OFFICES IN 4 DIFFERENT LOCATIONS FOR YOUR CONVENIENCE. IF YOU HAVE QUESTIONS REGARDING WHERE YOUR OFFICE APPOINTMENT IS LOCATED, PLEASE DON'T HESITATE TO CALL AND CONFIRM (972) 412-7700.

Rockwall *(Near Texas Health Presbyterian Hospital Rockwall)*

1005 W. Ralph Hall Pkwy
Suite 211
Rockwall, Texas 75032

Rowlett *(Behind Baylor Lake Pointe Hospital tower)*

6705 Heritage Pkwy
Suite 104
Rockwall, Texas 75087

Forney

375 Marketplace Blvd
Suite 190
Forney, Texas 75126

Greenville *(in the Baylor building)*

4400 IH-30 West
Suite 300
Greenville, Texas 75402

Terrell *(in the Baylor building)*

200 N. Virginia St.
Terrell, Texas 75160