The Endoscopy & Colonoscopy

PAYMENT POLICY AND FINANCIAL DISCLOSURE

Thank you for choosing us as your specialty care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask questions you may have, and sign in the space provided. A copy will be provided to you upon request.

For Billing Purposes, there are separate service components for which you will be billed separately:

A. **Physicians Professional Charge:** Your physician will bill this charge separately to you. This billing is for the physicians professional services that are provided during your procedure
B. **Facility Charge:** We will also bill a facility fee for the use of the Endoscopy & Colonoscopy Center in which your procedure is being performed.
C. **Laboratory and Pathology Charge:** If you have a biopsy taken or polyps removed you will receive a bill from the laboratory that processes your biopsy.
D. **Anesthesia Charge:** This billing is for the anesthesia that is provided during your procedure.

1. **Insurance-**We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected. Knowing your insurance benefits is **your** responsibility. We make every effort to verify your insurance and contact you regarding co-pays and deductibles.
2. **Co-payments and deductibles-**All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company, Failure on our part to collect copayments and deductible from our patients can be considered fraud. Please help us in upholding the Law by paying your co-payment at each visit.
3. **Non-Covered Services-** Please be aware that some –and –perhaps all-of the services you receive may be non-covered or not considered necessary by Medicare or other insurers.
4. **Proof of Insurance-**All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission-**We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not a party to that contract.
6. **Coverage changes-**If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Non-payment-**If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer you're account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During this 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed Appointments-**Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guide lines.

______________________________________ ____________________

Signature of patient or responsible party **Date**

______________________________________ ____________________

Name of Patient **Date of Birth**

Information on Anesthesia for Your Procedure

You will receive anesthesia for your procedure. This will **PROHIBIT** you from operating a motor vehicle until the next morning. To ensure the highest quality of safety for everyone, please be sure to arrive with an acceptable form of transportation. EMT (314) 781-6400 is accepted at this facility. Cabs, Uber and public transportation are not acceptable.

If you are being dropped off, your responsible party (transportation) is required to be available at the time of check in. During the time of check in, you will receive information regarding "check out" and "transportation". Your time with us **CAN** take up to 3 hours.

If you are unable to obtain proper transportation, you will need to call the office to reschedule. All appointments are required to be cancelled/rescheduled within 24 hours. Patients failing to cancel/reschedule as required will be subject to a $150.00 non-cancellation fee.

Anesthesia is a treatment used to block pain and awareness during medical procedures. Your anesthesia care will be delivered by a specially trained nurse, a Certified Registered Nurse Anesthetist (CRNA). You will meet your CRNA prior to your procedure. Please do not hesitate to ask questions or express concerns you may have.

Our CRNA's typically use Propofol based sedation. Propofol causes compete or near complete amnesia with a pleasant restful sleep. Memory and most cognitive functions return to normal in the recovery room prior to discharge. When injected, the Propofol may cause a burning sensation in your IV but only lasts 30 seconds. You will fall asleep. The CRNA will monitor your breathing and vital signs throughout the procedure. Profopol is an antiemetic, so nausea is rare. If you do develop nausea and/or vomiting, we have medications to help.

Surgery and anesthesia both have some risks. Fortunately adverse events are rare. Tell your CRNA if you have capped teeth, dental bridges or dentures. Loose teeth are particularly a risk as they may become dislodged and swallowed. Damage to teeth is always a risk with your procedure.

If you have an inhaler, bring it with you.

It is important that you **DO NOT** drink any liquids within **4 hours** of your scheduled procedure. You may drink clear liquids up to 4 hours prior to your scheduled time.

NOTE: Milk products, creamer, orange juice with pulp are not clear liquids. Also, do not drink any other liquids or eat anything (including chewing gum, candy or cough drops) for a minimum of 8 hours prior to procedure time. If you violate this, your procedure may be delayed or canceled. The only exceptions will be for medications by mouth. Use only a sip of water.

Our **GOAL** is to provide a safe and comfortable experience for our patients.

If you have any questions prior to your procedure, please contact the nurses at 314-373-8931.

ACKNOWLEDGEMENT

I ____________________________ have read the above instructions and I acknowledge that I am REQUIRED to have the appropriate RESPONSIBLE PARTY/TRANSPORATION in attendance at the time of check in for my procedure.

Patient signature____**Date:**_______________________________Z

The Endoscopy & Colonoscopy Center, LLC
&
Digestive Disease Specialists, Inc.
Registration Form
(Please Print)

DEMOGRAPHICS:

Patient Name (Last, First, Middle Initial): ______________________________

Maiden Name (If applicable): ____________________ E-mail address: ______________________

Address:______________________________ City:__________________ State:______ Zip:__________

Home Phone: (___)_______________ Cell Phone: (___)______________ Work Phone: (___)______________

Patient Social Security Number: _______-_____-_________ Date of Birth: _____/_____/_____ Sex: M _____ F_____

Marital Status: S M W D Ethnic Background (Please circle one): 1) Hispanic or Latino 2) Neither Hispanic or Latino

Race: (Please circle racial background) 1) White 2) Black or African American 3) American Indian or Alaska Native 4) Asian 5) Native Hawaiian/Pacific Island 6) Other not listed 7) Multi-Racial (two or more races) 8) Choose not to answer

Patient Employer: ______________________________ Occupation: ______________________

Employer Address: ______________________________ Phone Number: ______________________

Referring Physician Name______________________________ Physician Phone Number: ______________________

Address: ______________________________ Physician Fax Number: ______________________

MEDICAL INSURANCE INFORMATION:

Primary Insurance Company: ______________________________ Phone Number: ______________________

Policy/Member ID Number: ______________________________ Group Number: ______________________

Relationship to Policy Holder: ______________________ Policy Holder's Date of Birth: ______________________

Secondary Insurance Company: ______________________________ Phone Number: ______________________

Policy/Member ID Number: ______________________________ Group Number: ______________________

Relationship to Policy Holder: ______________________ Policy Holder's Date of Birth: ______________________

EMERGENCY CONTACT:

Name: ______________________________ Relationship to Patient: ______________________

Home Phone Number: ______________________ Alternate Phone Number: ______________________

RESPONSIBLE PARTY:

Name: Mr/Mrs/Ms: ______________________________ Social Security Number: ______________________

Address: ______________________________ City: ____________________ State: ______ Zip: __________

Home Phone Number: ______________________ Alternate Phone Number: ______________________

Responsible Party Signature:______________________________________ Date: ______________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize the release of any medical information necessary to process my health claims and request payment of benefits to the provider of service(s). I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the provider(s) for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required. I have been informed prior to the date of my scheduled procedure that the physician who is rendering services may have an ownership interest in the above referenced facility. I have also been given the choice to schedule my procedure at another facility. I wish to be treated at the Endoscopy and Colonoscopy Center, LLC. by Digestive Disease Specialists, Inc. physicians.

____

Signature Date

Riverside Ambulatory Surgery, LLC
The Endoscopy Center
100 Village Square
Hazelwood, MO 63042
314-373-8931

MEDICAL HISTORY

Name:______________________________ Date of Birth:______________ Today's Date:__________

Reason You are here:____

Primary Care Physician______________________ Fax number/telephone number______________________

1. Have you ever had a colonoscopy in the past? ☐ Yes ☐ No
   a. If the answer is yes, When and Where______________________________________
2. Is there a family history of Colon cancer or polyps? ☐ Yes ☐ No
3. Do you have any gastrointestinal symptoms such as abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia? ☐ Yes ☐ No   Heartburn, indigestion or difficulty swallowing ☐Yes ☐ No

If yes, please explain____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chronic Cough
☐ COPD
☐ Clotting Disease
☐ Congestive Heart Failure (CHF)
☐ Irregular heartbeat
☐ Crohns Disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Endocrine Problems
☐ GERD
☐ Glaucoma
☐ Hepatitis
☐ HIV/AIDS
☐ Hypertension
☐ Coronary Artery bypass
☐ Kidney Disease
☐ Dialysis
☐Thyroid
☐ Heart Attack/Myocardial Infarction When______
☐ Peptic Ulcer Disease
☐ Seizures
☐ Stroke When__________
☐ Ulcerative Colitis
☐ Short of Breath
☐Pacemaker/Defibrillator or Artificial heart valve
☐ Organ Transplant
☐ Stent Placement When_________
☐ MRSA
☐ Hernia

Social History:

Alcohol use- ☐ Never ☐ Occasionally ☐ Daily Type______________________________

Tobacco use- ☐ Never ☐ Previously, but quit When________ ☐ Packs per day______for_______Years

Drug use- ☐ Never ☐ Occasionally ☐ Daily Type______________________________

Allergies to medication or eggs? If so, please list____

____

Have you had difficulty with anesthesia other than nausea? ☐ Yes ☐ No

Are you able to walk without help? ☐ Yes ☐ NO

Do you use oxygen at home? ☐ Yes ☐ No   Sleep Apnea? ☐ Yes ☐ No   Do you use a CPAP? ☐ Yes ☐ No

Do you take any of these blood thinning medications? Please check any of the ones you take daily.
☐ Coumadin (warfarin) ☐ Aspirin ☐ Lovenox (enoxaparin) ☐ Pradaxa (dabigatan) ☐ Trental (petoxifylline)
☐ Plavix (clopidogrel) ☐ Eliquis (apixaban) ☐ Xarelto (rivaroxaban)
Last Dose Taken______________________________

Please Provide us with a current list of your medications.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Nurses Signature Date Time

______________________________ ______________
Physician Signature Date Time

Medication Reconciliation

Patient Name: ______________________ DOB: ____________ Age: _______ Ht: ________ Wt: __________
Primary Phone: ____________________ H: ________________ C: ________________ BMI: _______ KG: ______
Ride Home: ______________________________ Procedure: __________________________ DOS: ___________
Surgeon: _____________________________________
Preferred Pharmacy Phone: _______________________________ Fax: ____________________________________

Allergies

Name of allergy	Reaction or Sensitivity

Medications Prior to Admission

List all medications, vitamins, nutritional and/or herbal supplements, including medications administered via pump or patch prior to admission.

Medication, dosage, route, frequency	Reason Taken	Last Taken	Cont= Continue Medication DC= Discontinue Medication New= New Prescription Given
			Cont DC New

Pre Admission Medications Stopped

Instructed to stop taking any medications? Yes No
Last medication taken:
Date
Dosage:

RN Reviewed: ____ Date/Time: ____________________

Patient or Responsible Party Signature: ______________________________ Date/Time: ____________________

Physician Signature: ____ Date/Time: ____________________