

Dear \_\_\_\_\_

Your doctor has recommended a colonoscopy for colorectal cancer screening. Enclosed is a Patient Information form and an Advanced Beneficiary Notice (ABN) that must be filled out and sent back to our office located at Five Irongate Center, Glens Falls, NY, 12801, prior to us scheduling this procedure.

Enclosed is an Advanced Beneficiary Notice (ABN) that explains Medicare coverage for screening colonoscopies and when they may not cover this service. Please complete this form and return it to our office along with the Patient Information form.

We perform this procedure at Glens Falls Hospital, Saratoga Surgery Center, and Northern GI Endoscopy located at Five Irongate Center in Glens Falls.

Once the paperwork has been received, a medical assistant will call you to schedule the date for your procedure and optional educational planning session. **Please be prepared to have this form available when we call to enter the dates in the space below.**

The optional educational session will give you an overview of the procedure and the prep needed prior to the procedure. A nurse will be available to answer any questions. **You can also visit our website at [www.giassociatespc.com](http://www.giassociatespc.com) for further information including prep instructions and forms.**

**Patients failing to cancel their colonoscopy appointment at least 7 days in advance will be billed an administrative fee of \$100. This fee must be paid in full prior to scheduling future appointments. If you must cancel or reschedule the examination, please call 793-5034 at the earliest possible time. There are often significant delays in rescheduling and if there are any questions regarding the need to cancel due to sickness or other health issues, it is essential that you contact our office or our physician on call (after hours or on weekends).**

We thank you for your cooperation in advance. If you have any questions regarding these instructions, please call our office at **793-5034**.

Sincerely,

Gastroenterology Associates

**Date for Education Session** \_\_\_\_\_

**at GI Associates  
5 Irongate Center  
Glens Falls, NY**

**Date of your procedure** \_\_\_\_\_

**Place of your procedure** \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION for SCREENING COLONOSCOPY**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell phone #) \_\_\_\_\_  
E-mail \_\_\_\_\_ Marital Status S M W D Gender M F  
**\*Race:** Caucasian \_\_\_ Black \_\_\_ Hispanic \_\_\_ Asian \_\_\_ Other \_\_\_  
**\*Ethnicity:** Latino/Hispanic \_\_\_ Other \_\_\_  
**\*Language:** English \_\_\_ Other \_\_\_  
Patient's Social Security Number \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Other doctors involved in your care \_\_\_\_\_  
In Case of Emergency, Contact: \_\_\_\_\_ Phone # \_\_\_\_\_  
  
Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_

Have you previously been evaluated by any of our physicians: No \_\_\_ Yes \_\_\_ If yes, by whom \_\_\_\_\_

**\*These questions are required by the Federal Government, related to healthcare reform and the Affordable Care Act.**

**INSURANCE INFORMATION**

**Primary Insurance** \_\_\_\_\_  
Claim Address \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_  
Subscriber's ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
Claim Address \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_  
Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Patients failing to cancel their colonoscopy appointment at least 48 hours in advance will be billed an administrative fee of \$100. This fee must be paid in full prior to scheduling future appointments. If you must cancel or reschedule the examination, please call 793-5034 at the earliest possible time. There are often significant delays in rescheduling and if there are any questions regarding the need to cancel due to sickness or other health issues, it is essential that you contact our office or our physician on call (after hours and weekends).**

**CONTINUED ON OTHER SIDE →**

We need to know if you have a family history of colon cancer or colon polyps in a first degree relative (ie. mother, father sister, brother). Please list who had the problem and at what age they were diagnosed.

Family History of Colon Cancer? No\_\_\_ Yes\_\_\_ If yes, whom\_\_\_\_\_ Age diagnosed\_\_\_\_\_

Family History of Colon Polyps? No\_\_\_ Yes\_\_\_ If yes, whom\_\_\_\_\_ Age diagnosed\_\_\_\_\_

Any Past Sigmoidoscopy? No\_\_\_ Yes\_\_\_ If yes, who performed & date\_\_\_\_\_

Any Past Colonoscopy? No\_\_\_ Yes\_\_\_ If yes, who performed & date\_\_\_\_\_

Have you ever been tested for sleep apnea? Yes\_\_\_ No\_\_\_

If yes, do you have a diagnosis of sleep apnea? Yes\_\_\_ No\_\_\_

Height\_\_\_\_\_ Weight\_\_\_\_\_

Are you on any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please detail below

\*Please list your prescribed medications and over the counter drugs including vitamins and supplements.

MEDICATION	STRENGTH	FREQUENCY TAKEN

**ALLERGIES:**

**Medication Allergies:** \_\_\_\_\_

**Latex Allergy:** No\_\_\_ Yes\_\_\_

**Other Allergies** \_\_\_\_\_

Are you having any new/recent bowel problems? (i.e. Change in bowel habits, rectal bleeding

No\_\_\_ Yes\_\_\_

If yes, explain \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Office use only

Date form received in office \_\_\_\_\_ Dated Medical Assistant contacted patient \_\_\_\_\_

Date of Colonoscopy \_\_\_\_\_ Refusal by patient for Ed. Seminar Yes No

Patient Name:

Identification Number:

**Advance Beneficiary Notice of Noncoverage (ABN)**

NOTE: If Medicare doesn't pay for screening colonoscopy below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the screening colonoscopy below.

<b>Screening Colonoscopy</b>	<b>Reason Medicare May Not Pay</b>	<b>Estimated Cost</b>
Screening colonoscopy (G0121) if you have had a screening colonoscopy in the last 10 years, or if you have had a screening flexible sigmoidoscopy in the last 4 years. However, if either of these procedures were performed to investigate a GI complaint(s), these would not be considered screening procedure(s), and you would still be eligible for a screening colonoscopy.	Medicare will only pay for a screening colonoscopy every 10 years, or 4 years after a flexible sigmoidoscopy.	\$675

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the screening colonoscopy listed above.

**Note:** If you choose option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the screening colonoscopy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the screening colonoscopy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the screening colonoscopy listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227.TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>Signature:</b>	<b>Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.