BAPTIST HEALTH®

MEDICAL GROUP

Gastroenterology
3950 Kresge Way
Suite 207
Louisville, KY 40207
PHONE: 502.893.0220
FAX: 502.893.0563

Dear Patient:

Your physician has requested that a physician in our Gastroenterology group perform an outpatient colonoscopy. The American Cancer Society and the American Gastroenterology Association both recommend that everyone 50 years of age and older undergo a screening colonoscopy every ten years. A screening colonoscopy is performed to locate and remove precancerous polyps. Patients who have had precancerous polyps in the past may need to have a colonoscopy more frequently than every ten years.

We will perform this colonoscopy as safely, conveniently, and comfortably as possible. **To begin this process, please fill out the attached forms and return them with a copy of both sides of your medical insurance card to the address below:**

3950 Kresge Way, Suite 207
Louisville, KY 40207

While Medicare and most private insurers do pay for a screening colonoscopy, it is your responsibility to contact your insurance carrier to ensure that a screening colonoscopy is covered under your insurance plan. When checking your benefits, be sure to check both screening and diagnostic benefits. While you are coming in for a screening colonoscopy, it is quite possible it can turn into a diagnostic procedure, which may incorporate a deductible and more out of pocket expenses. A screening colonoscopy becomes diagnostic when polyps or lesions are removed, if you have a personal history of colon cancer or polyps or if you are having symptoms, such as, rectal bleeding, abdominal pain, etc. If you have any questions, please contact our billing department at (502) 893-0220 ext. 105.

The enclosed procedure scheduling form allows you to select a day of the week and the facility that is convenient for you. For your comfort, you will receive sedation during your procedure. Therefore, you will need a family member or a friend to accompany you to the facility, and drive you home following the procedure.

When we receive your completed packet, a physician from our office will review your medical history. It may be determined that you should be seen for an office consultation prior to scheduling your procedure. This may be due to a current health issue, a serious past medical issue or a certain medication you are taking. We will contact you to schedule your office visit if necessary, as well as your colonoscopy.

If you have any questions or concerns, please call our office at (502) 893-0220 ext. 106.
Thank you for allowing us to participate in your health care.

Sincerely,

Baptist Health Medical Group – Gastroenterology

OPEN ACCESS COLONOSCOPY / EGD

If you have a preference in the doctor that does your procedure, please circle the name below (if no preference one will be chosen for you):

Greenwell – Heine – Dobozi – Briley – Kaplan – Beauerle – Landes

Patient Registration Form

Patient Name: ______________________________ Sex: ____________
Race: ____________ Ethnicity: ____________ Preferred Language: ____________
Date of birth: ______________________________
Age: ______________________________
Social Security Number: ______________________________
Marital Status: ______________________________
Street Address: ______________________________
City, State, Zip: ______________________________
Home phone: ____________ Cell phone: ____________ Work Phone: ____________
Employer: ______________________________
Employer Street Address: ______________________________
Employer City, State, Zip: ______________________________
Spouse or Parent / Guardian: ______________________________
Spouse or Parent / Guardian Date of Birth: ______________________________
Spouse or Parent / Guardian Phone: ______________________________
Relation to Patient: ______________________________
Spouse or Parent / Guardian Employer: ______________________________
Spouse or Parent / Guardian Employer Street Address: ______________________________
Spouse or Parent / Guardian Employer City, State, Zip: ______________________________
Emergency Contact: ______________________________
Relation to patient: ______________________________
Contact information: ______________________________
Referring Physician: ______________________________
Primary Care Physician: ______________________________

Insurance Information – Please Send Copy of Insurance Card (Front and Back)

Primary Insurance: ____________ ID Number: ____________
Group Number: ____________ Phone Number: ____________
Insurance Address: ______________________________
Name of Insured: ____________ Date of Birth of Insured: ____________
Employer of Insured: ____________ Relation to patient: ____________

Secondary Insurance: ____________ ID Number: ____________
Group Number: ____________ Phone Number: ____________
Insurance Address: ______________________________
Name of Insured: ____________ Date of Birth of Insured: ____________
Employer of Insured: ____________ Relation to patient: ____________

Procedure Scheduling Form

Patient Name: ______________________ Date of Birth: ___________________________
Pharmacy Address and Phone Number: ____
Family / Referring Physician: ____
Family / Referring Physician Phone Number: ____________________________________

Please circle below which facility you would like to have your procedure performed at:

BHL – Baptist Health Louisville PSC – Premier Surgery Center

Please circle a day of the week most convenient for you and we will try and accommodate:

Monday Tuesday Wednesday Thursday Friday

Have you ever had a colonoscopy: ____
If yes, when: ____
Results of prior colonoscopy (if applicable):
Normal? ____
Colon cancer? ____
Colon polyps? ____

Do you take any of the blood thinners below (Please mark Yes or No):

Aspirin: Y / N
Plavix / Clopidogel: Y / N
Coumadin / Warfarin: Y / N
Effient: Y / N
Pradaxa: Y / N
Arixtra: Y / N
Lovenox / Enoxaparin: Y / N
Xarelto: Y / N
NSAIDS:
Aleve: Y / N
Motrin / Ibruprofen: Y / N
Naproxen: Y / N
Celebrex: Y / N
Meloxicam: Y / N

Name of Physician prescribing the medications above: ______________________________

Patient Name: ______________________ Date of Birth: ____________________

Past Medical History Information

Please indicate **Yes or No** if you have had any of the following:

High Blood Pressure:	Y / N
Low Blood Pressure:	Y / N
Stroke:	Y / N
Heart Attack / Heart Disease / Murmur / Heart Stent:	Y / N
Angina / Chest Pain:	Y / N
Allergies / Sinus Problems:	Y / N
Emphysema / COPD / Asthma:	Y / N
Lung Disease, TB:	Y / N
Arthritis:	Y / N
Diabetes:	Y / N
Rheumatic Fever:	Y / N
Liver Disease (Cirrhosis, Cysts, Hepatitis):	Y / N
Mono:	Y / N
Jaundice:	Y / N
Gallbladder problems (Stones):	Y / N
Thyroid Disease:	Y / N
Kidney (Failure / Stones):	Y / N
Stomach problems (ulcer, indigestion, reflux, hiatal hernia):	Y / N
Colon problems (polyps, ulcers, diarrhea, diverticulitis, spastic colon):	Y / N
Depression, Anxiety, Stress:	Y / N
Neurological disorders (Seizures, Fainting):	Y / N
Cancer (please specify): ________________	Y / N
Glaucoma / Cataracts:	Y / N
Anemia:	Y / N
Rectal bleeding:	Y / N
Vomiting blood:	Y / N
Motion sickness:	Y / N
Blood transfusions:	Y / N
Bleeding problems:	Y / N

Other (please specify): ____

Do you smoke?	Y / N	Frequency?: ____________________
Alcohol use?	Y / N	Frequency?: ____________________
Caffeine use?	Y / N	Frequency?: ____________________
Illegal drug use?	Y / N	Type / Frequency?: ________________

Past Surgery Information

Tonsils: Y / N	When: ________________	Uterus: Y / N When: __________
Appendix: Y / N	When: ________________	Ovaries: Y / N When: __________
Gallbladder: Y / N	When: ________________	Prostate: Y / N When: __________
Stomach: Y / N	When: ________________	Heart: Y / N When: __________
Colon: Y / N	When: ________________	Lung: Y / N When: __________
Kidney: Y / N	When: ________________	Breast: Y / N When: __________
Thyroid: Y/ N	When: ________________	Hernia: Y / N When: __________
Other: Y / N	When: ______________________________________	

Patient Name: ______________________________ Date of Birth: ____________________

Medical Information

Please indicate any current problems that you are currently having. These symptoms could include but are not limited to: (reflux, nausea, vomiting, problems swallowing meat or pills, rectal bleeding, abdominal pain, black stools, heartburn, weight loss, diarrhea, constipation, other):

____

____

Current Medications (include Herbs and Vitamins)

Medication	Strength	Frequency

Please list any allergies to medicines and reactions below:

____

____

____

____

____

Do you have a Family History of Colon Cancer? Y / N
Relation: ______________________________ Age at Diagnosis: ______________________

Do you have a Family History of Colon Polyps: Y / N
Relation: ______________________________ Age at Diagnosis: ______________________

Do you have a Family History of any Cancer? Y / N
Type: ____________________ Relation: ______________ Age at Diagnosis: ____________

Do you have a Family History of Crohn's Disease or Ulcerative Colitis? Y / N
Type: ____________________ Relation: _______________ Age at Diagnosis: ____________

Important Information

Because you will be sedated, you will not be able to drive after your colonoscopy or EGD. You must arrange for a responsible adult (over 18) who can drive or otherwise accompany you to and from the facility. You should be able to return to work without difficulty the following day.

Risk of Colonoscopy

While colonoscopy and EGD are outpatient procedures, it is an endoscopic procedure performed in a facility and certain risks are inherent to the procedure. You will be able to discuss the risks below with the physician on the day of your colonoscopy or EGD. A detailed informed consent form will be discussed with you on this day and you will be required to sign this form to undergo your procedure.

Risks of Colonoscopy: (Most common risks are listed; other rare risks / complications may not be listed below)

1. Abdominal pain.
2. Bleeding.
3. Infection.
4. Adverse reaction to sedation such as: allergic reaction (systemic or local), respiratory depression, low heart rate or low blood pressure.
5. Perforation (tearing of the colon) necessitating surgery to repair.
6. Inpatient hospital admission due to any of the above reasons.

By signing this page, I acknowledge that I will have a driver on the day of my procedure and that I have read the risks of this procedure.

____

Signature

____

Date

Authorization to Release Medical Information to Family Members or other Designated Person

Patient Name:________________________________Date of Birth: ____________________

I hereby authorize Baptist Health Medical Group to release any information regarding my health care to the person(s) below:

Name: ____ **Relationship**: _______________________

Phone Number: (   ) _______________________ **Fax Number: (   )** ________________________

Name: ____ **Relationship**: ______________________

Phone Number: (   ) _______________________ **Fax Number: (   )**_________________________

Name: ______________________________________ **Relationship**: _________________________

Phone Number: (   ) _______________________ **Fax Number: (   )** _______________________

Name: ____**Relationship**: _______________________

Phone Number: (   ) _______________________**Fax Number: (   )** _________________________

☐ I do not want information regarding my health care released to any family members or other designated person.

This form will remain in effect until it is updated by the patient or legal guardian.

____________________________________ ______________________________________

Signature Date of Birth Today's Date

PATIENT CONDITIONS AND CONSENTS

sex, disability or any other status protected by federal, state or local law.

7. **AIDS INFORMATION:** I acknowledge receipt of AIDS information. ___ Yes ___ No

8. **LATEX ALLERGIES:** I have a latex allergy ___ Yes ___ No

9. **ADVANCE DIRECTIVES:**
   - I acknowledge I have been offered a brochure describing my rights to make decisions about my medical care and advance directives. ___ Yes ___ No
   - I have an advance directive (e.g., living will, durable power of attorney, healthcare surrogate) ___ Yes ___ No

   If **Yes**:
   - ☐ I have presented a copy to my physician office.

     OR
   - ☐ I do not have a copy, but I have been advised to bring a copy to be placed in my chart. I understand that it is my responsibility to provide the physician's office with a copy of my advance directive.

   If **No**:
   Would you like more information about advance directives? ___Yes ___ No

10. **PRIVACY NOTICE AND RIGHTS:**
    - ☐ I acknowledge being offered a copy of Baptist's Notice of Privacy Practices.

      OR
    - ☐ I did not receive a copy of the Notice today, but received a copy previously.

11. **COMMUNICATION:**
    I have communication needs (language, hearing, vision). ___ Yes ___ No
    I have a companion, legal representative or support person with communication needs (language, hearing, vision). ___ Yes ___ No

12. **CONSENT TO WIRELESS TELEPHONE CALLS:** I hereby authorize Baptist and all third parties, including clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys or other agents who may work on their behalf (including their successors, assigns, affiliates, or agents), to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that may result in charges to me. I agree that methods of contact may include using automatic telephone dialing systems or other computer assisted technology.

13. **CONSENT TO EMAIL OR TEXT USAGE FOR HEALTHCARE COMMUNICATIONS:** If at any time I provide an email address at which I may be contacted, I consent to receiving healthcare communication at that email from Baptist. I further consent to Baptist communicating healthcare information, such as appointment reminders, to me on my wireless telephone through text.

The undersigned agrees that a copy of this consent, release and assignment of benefits may be used in place of the original copy. The undersigned authorizes Baptist to appeal on patient's behalf any adverse coverage determinations for treatment or services rendered by Baptist and further authorizes Baptist or its designee to represent patient during any appeal process. The undersigned certifies that he/she has read and agrees to this form and has received a copy.

Patient Name (print):______________________________ Medical Record ________________________

Signature:__________________________________Date:______________

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies he/she has read and agrees to this consent, release and assignment as guardian, parent, next of kin, designated surrogate, or power of attorney (as noted below) and has received a copy. (To the extent that the patient is unable to consent and has been appointed a legal guardian, please provide the name of the guardian and seek the guardian's consent for treatment.)

Print Name:_________________________________ Relationship to patient:________________________

Signature:__________________________________Date:______________________

CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND MEDICAL TREATMENT:
I voluntarily consent to care involving routine diagnostic tests, procedures and medical treatment as ordered by the Baptist Gastroenterology Associates physicians, including his/her assistants or designees. I consent to Allied Health students observing and participating in my care under the supervision of a qualified professional. This consent also includes testing for communicable and blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV), if a physician orders testing for diagnostic purposes or if there has been an exposure to healthcare personnel. No guarantee has been given to me as to the results that may be obtained from my care.

1. CONSENT TO USE AND DISCLOSURE OF INFORMATION:
I authorize Baptist Gastroenterology Associates and the independent practitioners on its medical staff to use and disclose information about me to carry out treatment, payment and healthcare operations. Examples of such uses and disclosures include, but are not limited to, providing information to: (a) any person, company, or entity (such as HMOs, insurance companies, workers' compensation carriers, my employer, the Medicare and Medicaid programs and their intermediaries and review organizations, and any other payor or its review organization or third party administrator) that is or may be liable for paying any claim for benefits arising out of services provided to me; (b) any independent practitioner providing services for me; (c) any providers who may be providing follow-up care to me; (d) any licensing or accrediting organizations necessary for Baptist Gastroenterology Associates to obtain or maintain licensure or accreditation; (e) ***any other persons or entities described in Baptist Gastroenterology Associates's Notice of Privacy Practices.*** This consent includes the release of medical records and billing information related to drug-related conditions, alcoholism, psychological and psychiatric conditions, and/or communicable or blood-borne infectious diseases, such as hepatitis, tuberculosis, and the human immunodeficiency virus (HIV). I also consent to any third party payor or its review organization paying for my care to discuss my plan of treatment for utilization review purposes.

2. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:
I agree that I am responsible for payment of my bill. Payment of any portion of my bill not covered by a third party payor is due from me unless Baptist Gastroenterology Associates has agreed to other arrangements.

I agree to the assignment of all third party payor benefits to Baptist Gastroenterology Associates and to any physician and independent practitioner providing services for me. I agree to pay Baptist Gastroenterology Associates, physicians, and independent practitioners for all charges for services which are not covered or paid by any third party payor regardless of the reason, including but not limited to a determination by any third party payor that such services are not covered services or medically necessary. After reasonable notice, any unpaid account may be turned over to a collection agency and/or attorney for collection. Should it be necessary for Baptist Gastroenterology Associates to pursue collection, I agree to pay all reasonable collection costs, including court costs and attorney's fees incurred by Baptist Gastroenterology Associates in collecting my account.

3. BAPTIST GASTROENTEROLOGY ASSOCIATES IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ARTICLES:
I understand that Baptist Gastroenterology Associates is not liable for the loss of or damage to money, jewelry, glasses, dentures, documents, clothing, or other items of personal property.

5. SMOKE-FREE ENVIRONMENT:
Baptist Gastroenterology Associates maintains a smoke-free environment. Smoking is prohibited by health care personnel, patients, and visitors except in designated areas outside the building.

6. PRIVACY NOTICE AND RIGHTS:

(a) I acknowledge receiving a copy of Baptist's Notice of Privacy Practices. _____ Yes
OR
(b) I did not receive a copy of the Notice today, but received a copy previously. _____ Yes

The undersigned agrees that a copy of this consent, release and assignment of benefits may be used in place of the original copy. Further, the undersigned certifies that he/she has read and agrees to this form and has received a copy.

Patient Name (print) ______________________ Social Security #: ______________________

Signature: ______________________ Date: ______________________

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies he/she has read and agrees to this consent, release and assignment as (guardian) (parent) (next of kin) (designated surrogate) (power of attorney) **[CIRCLE THE WORDS THAT ARE APPROPRIATE]** and has received a copy.

Print Name:______________________ Relationship to patient:______________________

Signature:______________________ Date:______________________