COLON AND RECTAL ASSOCIATES, LTD.

1235 Old York Road, Suite G 20 * Abington, PA 19001 * Tel: 215-517-1250 * FAX 215-517-0821
Joseph H. Nejman, M.D.
Steven G. Harper, M.D.
D. Mark Zebley, M.D.
Steven A. Fassler, M.D.
Soo Y. Kim, M.D.

Colon and Rectal Associates has developed a program of streamlined access to having a colonoscopy performed called OPEN ACCESS. OPEN ACCESS allows healthy patients, without exclusion criteria, to receive their colonoscopy without an initial office consultation. Patients must be in stable and good health, with no active gastrointestinal/medical conditions or complaints. The practice requires completion of an initial questionnaire which will be reviewed by staff and if circumstances are deemed appropriate, the procedure will be scheduled. If you are not considered appropriate for OPEN ACCESS, then the staff will assist you in arranging for an office consultation. At any time during the process, patients may feel free to arrange for an in-person consultation in the office with one of our physicians, as the physician will not have the time during your Open Access procedure to discuss your medical history and current issues as is customarily available in the office setting.

Enclosed you will find:

- Patient Health Inventory
- Open Access Colonoscopy Information Letter
- Bowel Preparation Instructions
- Procedure Consent Form

Please complete the Health Inventory, SIGN the information letter and return them to our office. It may take up to 2 weeks to have your information processed and reviewed.

Thank you for choosing Colon and Rectal Associates as we look forward to taking care of your colon and rectal health needs.

The Physicians of Colon and Rectal Associates

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OPEN ACCESS COLONOSCOPY INFORMATION

Dear _____,

Thank you for selecting Colon and Rectal Associates for your colonoscopy needs. This letter is to inform you of the procedure and preparation details, some of which you will receive under a separate enclosure.

Colonoscopy is a two day undertaking. The preparation instructions for the laxative program are outlined in detail in a separate attachment.

With regards to any medications you are currently taking, we will review your list and discuss with you which, if any, medications need to be discontinued ahead of time, and which, if any, medications need to be taken on the morning of your colonoscopy before you leave the house(with just enough water to get them down). You may brush your teeth, rinse and gargle, but you are not permitted to drink any liquids, chew gum or consume breath mints.

Arrive at the facility the next morning about one hour prior to your appointment time. You'll be checked into the Center. You have been sent a Procedure Consent Form with this packet. **It is imperative that you sign this document and bring it with you to the Facility on the day of your procedure.**

The nursing staff will get you prepared for the procedure. You'll change into a procedure gown and have an IV placed for later administration of fluids and medications. You will have the opportunity to meet the anesthesia team at that time and they will go over with you their participation in the procedure.

The procedure is performed under a twilight anesthesia, and once you are well sedated, the flexible tube (the colonoscope) will be passed around the entire colon. If any abnormalities are encountered, they will be removed at that time, if technically possible, or biopsied to be interpreted by the pathologist at a later time. You will spend a period of time in the recovery area and then your driver will take you home where you should rest the remainder of the day. Because you have received intravenous drugs, you are prohibited from driving a car that day. We discourage you from making any important decisions and from drinking alcohol on that day, as well.

Every procedure in medicine carries potential risks. The major risks of colonoscopy include bleeding (which is only an issue if a polyp is removed—incidence 1:500 polyp removals), creation of a perforation, tear or hole in the bowel (1:2500-3000 procedures), and the possibility of missing an abnormality in the colon because no test in medicine is 100% accurate. If a perforation were to develop, it would require an urgent trip to the operating room for surgical repair.

We ask that you sign the bottom of this form indicating that you have read this document and understand its contents. If you should have any questions or concerns to discuss with us, you may opt to set up an office consultation before your procedure.

We look forward to taking care of you.

Sincerely,
Colon and Rectal Associates

I have read the instructions above and understand its contents.

Patient Signature	Printed Name	Date

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COLON AND RECTAL SURGERY
PROCTOLOGY

OPEN ACCESS

PATIENT INFORMATION

NAME: _____ REFERRING DOCTOR: _____

ADDRESS: _____ FAMILY DOCTOR: _____

CITY/STATE/ZIP CODE: _____ CARDIOLOGIST: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ SOCIAL SECURITY #: _____

AGE: _____ DATE OF BIRTH: _____ GENDER: MALE_____ FEMALE_____

MARITAL STATUS: MARRIED_____;DIVORCED_____;SINGLE_____;WIDOWED_____;PARTNER_____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S SOCIAL SECURITY #: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE#:** _____

RACE: ASIAN_____ HAWAIIAN/PACIFIC ISLANDER_____ BLACK/AFRICAN AMERICAN_____
WHITE_____ HISPANIC_____ OTHER_____ REFUSED_____

ETHNICITY: HISPANIC OR LATINO_____ NON-HISPANIC_____ REFUSED_____

LANGUAGE: ENGLISH_____ OTHER_____ (SPECIFY: _____)

OCCUPATION: _____

PATIENT'S EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

PRIMARY INSURANCE CO. AND ADDRESS: _____

_____

SUBSCRIBER'S NAME: _____ ID#: _____ GRP#: _____

SECONDARY INSURANCE CO. AND ADDRESS: _____

_____

SUBSCRIBER'S NAME: _____ ID#: _____ GRP#: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other private insurance, and any other health plan to **COLON AND RECTAL ASSOCIATES, LTD.**
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____ DATE _____

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE PAGE 2
OPEN ACCESS

Name: _____ **Height:** _____

Date: _____ **Weight:** _____

Reason for Colonoscopy: _____

_____

If you have had bleeding, circle the appropriate description(s):
Blood has been: Bright red – Mixed with the stool – On surface of stool – On the toilet tissue – In the toilet bowl – On underclothes

Do you have currently, or have you had in the past, any of the conditions listed below:

____ Yes ____ No Colon or rectal cancer. If yes, age diagnosed _____
____ Yes ____ No Colon or rectal polyps. If yes, age diagnosed _____
____ Yes ____ No Personal history of any other type of cancer. Age of diagnosis _____
What type? _____
____ Yes ____ No Inflammatory bowel disease (Crohn's disease or ulcerative colitis)
____ Yes ____ No Diverticulitis
____ Yes ____ No Diverticulosis
____ Yes ____ No Previous colon or rectal surgery
____ Yes ____ No Previous abdominal surgery
____ Yes ____ No Previous anal surgery
____ Yes ____ No Rectal bleeding
____ Yes ____ No Constipation, diarrhea or change in bowel habits
____ Yes ____ No Fecal Incontinence
____ Yes ____ No Recent fevers
____ Yes ____ No Weight loss
____ Yes ____ No Blindness
____ Yes ____ No Previous organ transplant
____ Yes ____ No Blood Disorder(s), e.g. Von Willebrand's Disease
____ Yes ____ No Heart Valve
____ Yes ____ No Coronary Artery Stents
____ Yes ____ No Defibrillator
____ Yes ____ No Pacemaker
____ Yes ____ No Chest pain or angina
____ Yes ____ No Myocardial infarction (heart attack)
____ Yes ____ No Palpitations or Arrhythmias
____ Yes ____ No Previous heart surgery
____ Yes ____ No Hypertension (high blood pressure)
____ Yes ____ No Stroke
____ Yes ____ No Claudication (Poor Blood flow to the legs)
____ Yes ____ No Blood clot in the legs
____ Yes ____ No Blood clot in the lungs (pulmonary embolism)
____ Yes ____ No Asthma or Emphysema
____ Yes ____ No Pneumonia
____ Yes ____ No Sleep Apnea. If yes, require CPAP? ____ Yes ____ No
____ Yes ____ No Kidney failure/dialysis
____ Yes ____ No Urinary or prostate problems/Prostate cancer
____ Yes ____ No Radiation treatments for cancer
____ Yes ____ No Impotence
____ Yes ____ No Diabetes
____ Yes ____ No Thyroid problems
____ Yes ____ No Have you taken steroids (Prednisone, etc.) in last 30 days
____ Yes ____ No Arthritis

OPEN ACCESS

NAME _____ **DOB** _____

___ Yes ___ No Neurologic illness
___ Yes ___ No Psychiatric illness

___ Yes ___ No Previous blood transfusion
___ Yes ___ No Easy bleeding or bruising
___ Yes ___ No Anemia
___ Yes ___ No HIV Positive
___ Yes ___ No Have you taken aspirin or non-steroidal anti-inflammatory drugs (Ibuprofen, etc.) within the last 7 days?
___ Yes ___ No Gallbladder disease or gallstones
___ Yes ___ No Liver disease or cirrhosis
___ Yes ___ No Ulcer of the stomach or duodenum (small intestine)
___ Yes ___ No Gastritis (inflammation of the stomach)
___ Yes ___ No Diseases of the Pancreas

Are there any other medical problems that we should be aware of:_____

_____

___ Yes ___ No Do you smoke cigarettes currently? Packs/day: _____
___ Yes ___ No Have you ever smoked? Year you quit smoking:_____
___ Yes ___ No Do you drink alcohol? Drinks/week: _____
___ Yes ___ No Have you ever been treated for alcoholism?
___ Yes ___ No Have you ever used intravenous drugs?
___ Yes ___ No Have you ever had a Cat Scan? Date: _____
___ Yes ___ No Have you ever had a Barium Enema? Date: _____
___ Yes ___ No Have you ever had a Colonoscopy? Date: _____
___ Yes ___ No Have you ever had a Flexible Sigmoidoscopy? Date: _____

___ Yes ___ No Are you currently employed?
Occupation: _____
___ Yes ___ No Are you married?
___ Yes ___ No Do you have children?
Vaginal Deliveries ___ Yes ___ No
Episiotomies ___ Yes ___ No

Past Surgeries:
Please list your previous surgeries:_____

_____

FAMILY HISTORY
Do you have a <u>first-degree relative</u>, <u>who before the age of 50</u>, was diagnosed with Cancer?

___ Yes ___ No If yes, who?_____
What type? _____
Age at diagnosis _____

Do you have 3 or more relatives with Colon or Rectal Cancer? Yes_____ No_____

Has anyone else in your family had the following:
___ Yes ___ No **Colon or Rectal Cancer** (Please circle)
If yes, who?_____
___ Yes ___ No **Other Cancer**
If yes, who?_____
What type? _____
___ Yes ___ No **Colon or Rectal Polyps**
If yes, who?_____
___ Yes ___ No **Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)**

OPEN ACCESS

PATIENT'S NAME _____ **DOB** _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE#: _____

MEDICATIONS:

_____ I am **not** currently taking any prescription or over the counter medications.

_____ I currently take the following medications:

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS, VITAMINS, AND SUPPLEMENTS.

NAME OF DRUG	DOSAGE	FREQUENCY

Drug Allergies:

_____Yes_____ No Do you have any drug allergies?

If yes, please name the drugs to which you are allergic:

_____

_____

_____

_____

PATIENT SIGNATURE _____

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A. PATIENT PRIVACY NOTICE

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

(You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at www.colonandrectalassoc.com)

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ **Date**_____

B. RELEASE OF MEDICAL and BILLING INFORMATION

I, _____**, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:**

Name:_____ **Relationship:**_____

I, _____**, do not authorize anyone to have access to my billing and medical information.**

I understand that by signing this release, the designated person(s) above will be able to speak to any member of Colon and Rectal Associates' staff. Furthermore, I understand the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointments.

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ **Date:**_____

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes No

I give consent for the office to leave results of testing on my answering machine, by text, voicemail or with a spouse, parent or other household member. Yes No

Billing Policy of Colon and Rectal Assoc, LTD

Thank you for choosing Colon and Rectal Associates, LTD. Our mission is to exceed your expectations by providing high quality care and achieving patient satisfaction. Your health and well being is of the utmost importance to us. We have recently updated our billing policy. The cost of providing high quality care continues to rise and these changes are necessary to ensure that your needs are met. Effective June 1, 2017 our billing policy will be as follows:

1. **All co-pays are due at time of service in order to be seen.** Please contact your insurance company directly to confirm your co-pay amount for a specialist visit.

2. **All referrals are due at time of service in order to be seen.** We suggest you contact your PCP prior to your appointment with our office to confirm a referral was sent. Please request the confirmation number and date the referral was issued.

3. **All balances must be paid prior to services being rendered.** All patient balances are due within 30 days of the statement date.

4. **All patient balances and out of pocket fees including but not limited to, co-pays, co-insurance and deductible are due no later than 48 hours prior to your scheduled procedure for service to be rendered. Please be advised you will be given an estimate for our physician's portion of your scheduled procedure and the amount is subject to change. You may also receive bills from the facility and the anesthesia physicians.** After your claim is processed by your insurance carrier, if your remittance does not correspond with your insurance carrier's allowance, you will be billed for the difference or refunded for any overpayment.

We apologize for any inconvenience this may cause. However, no exceptions can be made as that would be a violation of our insurance contracts. As per the contractual agreement with our insurance carriers, we are unable to see patients without a co-pay or referral.

Please sign and date this document and return to the receptionist at your next appointment.

If you have any questions regarding this policy please contact the office manager, Kelly Smith at

215-517-1250.

_____ _____

Patient signature Date