Graham J. Sellers, M.D. Craig L. Brown, M. D. Warren J. Strutt M. D.

Welcome to SurgOne P. C.

Colon and Rectal Clinic of Colorado

Phone: 303 839 5669

Your first step to scheduling your colonoscopy is to complete your packet and send it back to our office including a copy of the front and the back of your insurance card.

After we receive your completed paperwork we will call you to schedule your appointment.

By mail: 1601 E. 19th Ave. Suite 6300, Denver, Colorado 80218

By Fax: 303 839 1216

This Packet includes:

New Patient Paperwork- please complete and return

Patient guide to colonoscopy for your information

Colonoscopy Consent Form- please sign and return

Information concerning your Outpatient Procedure for your information

Health Information and consent Form-please complete and return

Financial and Hippa Policy- please sign and return

If your insurance requires a referral, please contact your primary care doctor's office. Referrals need to be received prior to scheduling your appointment.

COLON AND RECTAL
CLINIC OF COLORADO

SurgOne, P.C.

I authorize this office to contact me via unsecure email: ___*Yes* ____*No*

PATIENT INFORMATION

Patient Email Address: _____

Requesting/Referring Physician_____ **Primary Care Physician**_____

Name (Legal): ***Last***:_____ ***First***:_____ ***M.I.***____ ***Mr. Mrs. Ms.*** Nickname:_____

Address:_____ ***City***:_____ ***State***:_____ ***Zip***:_____

Sex: M F ***Martial Status***: S M W D ***SS#***:_____ ***Date of Birth***: ____ ____ ____ ***Age***:____
MM DD YYYY

Race:_____ ***Ethnicity:*** _____ ***Preferred Language:*** _____

Phone: ***Home*** ( ) _____ ***Work*** ( ) _____ ***Cell/Pager*** ( ) _____

Patient's Employer:_____ ***Patient's Occupation***:_____

Employer's Address:_____ Employer's Phone #:_____

Spouse/Guardian Name:_____ ***Date of Birth*** ____ ____ ____ ***SS#***_____
MM DD YYYY

Address (If different from patient):_____ City:_____ State:____ Zip:_____

Spouse/Guardian Employer:_____ Employer's Address:_____

Spouse/Guardian Home Phone:_____ ***Work Phone***:_____ ***Cell/Pager***:_____

Person Responsible for Payment of Services (If different from Patient):_____

Emergency Contact: Relative/Friend, **not living with you**:

Contact:_____ Phone #:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Long Term Contact: Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from address given in patient info. above).

Contact:_____ Phone#:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Legible Copy of Ins. Card **Copy of Driver's License**

PRIMARY Insurance:_____ ***Subscriber ID#***:_____

Group#_____ ***Mailing Address (for claims)***:_____

Policy Holder Name_____ ***Relationship***: Self / Spouse / Child / Other_____

Policy Holder **DOB:**_____ ***Phone #:*** ( )_____ ***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **If Accident**: WorkComp or Auto: Date of Injury _____ Claim No._____

SECONDARY Insurance:_____ ***Subscriber ID#***:_____

Group#_____ ***Mailing Address (for claims)***:_____

Policy Holder Name_____ ***Relationship***: Self / Spouse / Child / Other_____

DOB:_____ ***Phone #:*** ( )_____ ***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **If Accident**: WorkComp or Auto: Date of Injury _____ Claim No._____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION,, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X_____(Signed) Date:_____

SurgOne, P.C.

Graham J. Sellers, MD Craig, L. Brown, MD Warren J. Strutt, MD

Medical History/Review Of Systems

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician _____ Primary Physician _____

Reason for Visit (Chief Complaint): _____

List all Significant **Medical Problems**	Please list all **Medications** and their doses:
1	**ASPIRIN YES OR NO** Dose
2	2 Dose
3	3 Dose
4	4 Dose
5	5 Dose
6	6 Dose
7	7 Dose
8	8 Dose

List **ALL PAST SURGERIES** you have had and the approximate date

1

2

3

4 _____

ALLERGIES: (please list) Are you allergic to any medications, tapes, latex, etc.

_____

ENDOSCOPIC HISTORY

List years of all previous colonoscopies _____ **Findings?** _____

List years of all previous upper endoscopies _____ **Findings?** _____

SOCIAL HISTORY

Do you smoke? _____ (if so how much per day?) _____ If you have smoked, when did you quit? _____

Do you drink alcohol? _____ If so, how many drinks per day? _____

List any non-prescribed drugs or supplements used: _____

Are you on any type of special diet? Please describe _____

FAMILY HISTORY Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Reaction to Anesthesia _____ Breast Cancer _____

Bleeding or clotting problems _____ Ovarian Cancer _____

Heart Attacks _____ Colon Cancer _____

Diabetes _____ Rectal Cancer _____

Blood Pressure Problems _____ Any other Cancers _____

Anything else your physician should know about your health or your family's health?

Name:_____ Date of Birth:_____ Todays Date:_____

Pharmacy name & Phone number:_____

Personal Medical History

Please check all that apply:

History of Diverticulitis__
Multiple Sclerosis__
Heart Attack__
Supplemental Oxygen__
Heart Disease__
Congestive Heart Failure__
Excessive Bleeding Disorder__
Herpes/Genital__
AIDS/HIV__
Glaucoma/Cataracts__

History of UTI__
Kidney Disease__
Thyroid Abnormalities__
Asthma__
Pulmonary Embolism__
Problems with Surgical Anesthesia__
Emphysema__
COPD__
Sleep Apnea__
Historoy of Colitis__
History of Warts (HPV)

High Blood Pressure__
History of Blood Clots__
Malignant Hyperthermia__
History of Ulcerative Colitis__
Pancreatitis__
Diabetes__
Difficult Airway Intubation__
History of Artery Stent__
DVT__
Stomach Ulcers__
History of Crohns Disease__

Review of Symptoms

Constitutional:
Fevers__
Chills__
Weight Loss__
Night Sweats__
Fatigue__

Cardiac:
Heart Murmur__
Palpations/Heart Racing__
Chest Pain__
Fainting__

Neurologic:
Numbness__
Memory Loss__
Loss of Strength__
Convulsions__
Headache __

Respiratory:
Shortness of Breathe__
Bloody Cough__
Wheezing__

Musculoskeletal/Skin:
Back/Neck/Joint Problems__

GI:
Abdominal Pain__
Naseau/Vomiting__
Constipation__
Diarrhea__
Jaundice__
Change in Bowel Habits__
Rectal Bleeding or Pain__

Ears/Nose/Throat:
Ringing in Ears__
Vertigo (Diziness)__
Hoarsness-Chronic__

Genitourinary:
Pain Urinating__
Burning__
Blood in Urine__
Increased Nightime Frequency__

Endocrine:
Tired/Sluggish__
Loss of Hair__
Easy Bleeding__
Easy Bruising__
Temp. Intolerance__

Skin:
Chronic Itching__
Skin Rash__

Eyes:
Double Vision__

Psychological/ Emotional:
Depression__
Anxiety__
Mood Swings__

Cancer:

Type: _____ _____ _____
When: _____ _____ _____
Treatment: _____ _____ _____

Patient Guide to Colonoscopy

A colonoscopy is an internal examination of the colon (large intestine), using an instrument called a colonoscope. The colonoscope is a small camera attached to a flexible tube. Unlike sigmoidoscopy, which examines the lower part of the colon, colonoscopy examines the entire length of the colon. A colonoscopy exam is used for many reasons, one of which is to check for colon cancer in people, even if they do not have any symptoms of the disease.

Reason for Colonoscopy

- To screen for colon cancer
- To take tissue specimens for biopsy
- To evaluate anemia (fewer than normal number of red blood cells)
- To evaluate blood in the stool, abdominal pain, persistent diarrhea, or other abnormalities
- To check type and extent of inflammatory bowel disease
- To check for colon cancer following a previous finding of polyps or colon cancer

Q & A

What happens during the procedure?

During the colonoscopy, you will lie on your left side with your knees drawn up toward your chest. After receiving a sedative and pain reliever, the colonoscope is inserted into the anus and gently moved through the colon. Air will flow through the scope to provide a better view and you may feel some abdominal cramping or pressure. Tissue samples may be taken with tiny forceps inserted through the scope, and polyps (abnormal tissue) may be removed. The exam usually takes about 20 minutes to one hour.

How do I prepare for a colonoscopy?

Before the procedure, you will thoroughly cleanse your bowel so your doctor has a clear view during the exam. Your doctor will give you specific instructions on how to prepare for the test, including what to eat or drink and how to use special preparations to cleanse your bowel. This process is very important because if everything has not been removed form your intestines, the procedure could take longer, there is greater risk for complication, the physician may not be able to finish the colonoscopy properly, and you might have to do it all over again sooner than normal.

What happens after the procedure?

It takes about an hour to partially recover from the sedative. Someone should help you get home because it can take up to a day for the full effects of the sedative to wear off. Rest and do not drive for the remainder of the day. You may feel bloated or pass gas for a few hours after the exam. Walking may lessen your discomfort. It is also normal to see a small amount of blood with your first bowel movement. However, see you doctor if you continue to pass blood or blood clots, have persistent abdominal pain, or have a fever of 100°F or higher.

RESOURCES

Mayo Clinic
www.mayoclinic.com/health/colonoscopy/C000009

Center for Disease Control and Prevention
www.cdc.gov/cancer/colorectal/basis_info/screening

American Gastroenterological Association
www.gastro.org/wmspage.cfm?parm1=861

From the office of: SurgOne
Dr. Graham Sellers, Dr. Craig Brown, and Dr. Warren Strutt
Professional Plaza West
1601 E. 19th Ave. Ste., 6300
Denver, CO 80218

Colonoscopy
Informed Consent

You and your doctor are considering a procedure called "Colonoscopy". This is a procedure in which the doctor inserts a special scope into the gastrointestinal tract. This scope allows the doctor to see inside the colon, and to perform procedures.

The removal of polyps and a biopsy of the colon are the most common procedures done during a Colonoscopy. These procedures are done to aid in the diagnosis of colorectal disease and to prevent the spread of Cancer. Your doctor can make no guarantee that this procedure will be successful in making either a diagnosis or a cure.

Significant complications from a Colonoscopy are very uncommon (less than 0.3%), but they do occur.

Bleeding- It is possible for some bleeding of the colon to occur with this procedure. If bleeding should occur, it usually stops by itself. Only in rare cases will blood transfusion ever be necessary.

Perforation- A very rare, but significant complication is Perforation. This is an injury to the lining of the colon by the instrument, which could result in leaking of the digestive products into body cavities. If this occurs, surgery to repair the injury is often necessary. Statistically, this happens in less than 1 in every 2,000 patients who have a Colonoscopy.

Other potential risks include localized irritation of the vein where the medication was injected, a reaction to the sedatives used, aspiration of saliva or stomach contents, fever that requires antibiotics, or a complication from a pre-existing medical condition, such as Heart or Lung disease or Diabetes.

Furthermore, there may be alternatives to this procedure available to you; such as the use of other diagnostic tests, Virtual Colonoscopy and the Barium Enema evaluation. However, these alternative methods carry their own risks or complications and varying degree of success.

I certify that I have read, or had read to me, the contents of this form. I understand the risks and alternatives involved with this procedure. I will be given the opportunity to ask any questions which I may have, and I do have the option to further discuss this consent with the doctor.

*Signed:*_____ *Date:*_____

(Patient or Person legally authorized to consent for patient)

Graham J. Sellers, M.D. Craig L. Brown, M.D. Warren J. Strutt, M.D.

Information Concerning Your Outpatient Procedure

Dear Patient:

This letter is to inform you of all possible fees that could occur as a result of your planned procedure. These are in addition to the charges submitted to your insurance by your Surgeon, Dr. Graham J. Sellers, Dr. Craig L. Brown or Dr. Warren J. Strutt.

1) Medical Facility- This is the hospital or surgical center where your procedure will take place. You will see separate charges from the facility submitted to your insurance. Co-pays and deductibles, as outlined by your plan, will apply.

2) Anesthesiologist- If anesthesia is necessary for your planned procedure. You will see separate charges from the anesthesiologist submitted to your insurance. Co-Pays and deductibles, as outlined by your insurance, will apply.

3) Pathologist- If your planned procedure results in biopsy, the sample will be sent to a Pathologist. You will see separate charges from the Pathologist submitted to your insurance. Co-pays and deductibles, as outlined by your insurance, will apply.

4) Special Information regarding Colonoscopy- If your Colonoscopy is scheduled as a Cancer Screening and the doctor discovers a polyp, he will remove it, your procedure has now changed from screening to surgery. Please be aware that with some insurance companies this may affect out-of-pocket responsibility for the procedure. Some insurance companies consider **High Risk** (people with family history or personal history of polyps or Cancer) to be diagnostic Colonoscopies, while other insurance companies cover them as preventative. Check with your insurance company to see what the guidelines are.

Our office will pre-authorize your planned procedure, if required, with your insurance company. However, the portion, you, the patient, are responsible for is determined by your particular insurance plan. For details on what your responsibility is, please call the customer service number on your insurance card.

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***

PATIENT NAME: _____ Birth Date:_____

		May we leave a message?		May we discuss your care?	
HOME PHONE:	_____	Yes	No	Yes	No
WORK PHONE:	_____	Yes	No	Yes	No
CELL PHONE:	_____	Yes	No	Yes	No
EMAIL ADDRESS:	_____	scheduling purposes only email is an unsecure email			

Please carefully consider with whom we may leave messages and/or whom you wish to have access to your medical/billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

Email will only include scheduling information no medical information will be sent

Medical information can be sent through our secure portal email

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make complete insurance information available to SurgOne, P.C. for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. may not bill for those services. You may receive a separate statement from the surgical assistant. These services may or may not be covered by your health insurance plan.
- If you undergo a surgical procedure, in addition to a bill from your surgeon, you may also receive bills from the hospital or surgical center where the procedure is performed, regarding anesthesia, pathology/lab, radiology and various consultants.

- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- SurgOne, P.C. is committed to providing the best treatment for our patients; however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 24-hour notice for canceling any appointments.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.
- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

Notice of Privacy Practices Acknowledgment
I acknowledge that I am in receipt of Privacy Practices for SurgOne PC
(Copy available in office)

_____
Printed name

_____ _____
Signature Date

_____ _____
Legal Guardian Printed Name Relationship to patient

_____ _____
Legal Guardian Signature Date

09/2015