UNIVERSITY GASTROENTEROLOGY

1930 Alcoa Highway, Suite A-145, Knoxville, Tennessee 37920
Phone (865) 305-6570 Fax (865) 305-6576

SCREENING COLONOSCOPY

Your physician recommends that you undergo a colonoscopy procedure to screen for colon cancer.

- The *American Cancer Society* recommends a colonoscopy for everyone 45 years of age and older.
- A colonoscopy may be recommended earlier if you have a family member with a history of colon cancer.
- A colonoscopy may reduce your lifetime risk of colon cancer.

University Gastroenterology is dedicated to providing you with the best care and service possible. Our experienced scheduling assistants are available to walk you through the entire screening process. They can answer any questions or concerns you may have while letting you know what you can expect before, during and after your procedure. They will work closely with your insurance company to identify your individual coverage and will communicate any potential coverage issues prior to your appointment.

- You may mail it to our office along with a current copy of your insurance card(s) to:
  University Gastroenterology
  1930 Alcoa Highway, Suite A-145
  Knoxville, Tennessee 37920

- You may fax it to our office along with a current copy of your insurance card(s) to:
  865-305-6576

Our dedicated physicians and friendly staff look forward to providing you with exceptional patient care.

UNIVERSITY GASTROENTEROLOGY

Dr. Sangeeta (Sandy) Gulati Dr. Carlos A. Rollhauser Dr. Benjamin P. Dalton
Dr. Thomas L. Young Dr. Shaker Barham Tausha Monday, APRN
1930 Alcoa Highway, Suite A-145, Knoxville, Tennessee 37920
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Last Name _____ First Name _____ MI _____ Birthdate _____ Social Security Number _____

In the past 10 years have you had a colonoscopy by any other Gastroenterologist anywhere? If so,

Doctors Name _____ Phone Number _____ When? _____

MEDICAL HISTORY

- ❑ Personal History of Colon Cancer or Polyps? If so, when _____
- ❑ Family History of Colon Cancer Who? _____ AGE: _____

Are you currently Having? *(check all that apply)*

- ❑ Change in bowel habits
- ❑ Rectal Bleeding
- ❑ Abdominal Pain

Other History: *(check all that apply)*

- ❑ Heart Disease
- ❑ Heart Valve Disease
- ❑ Bleeding/Clotting Disorder
- ❑ Diabetes _____
- ❑ Hypertension
- ❑ Sleep Apnea/CPAP machine
- ❑ Renal Disease
- ❑ Artificial Hips and/or knees
- ❑ Transplant
- ❑ Oxygen
- ❑ Rheumatic Fever
- ❑ Pacemaker/Defibrillator, Valves or Stents
- ❑ Endocarditis
- ❑ Recent Bypass within the last year

Are you currently taking any *blood thinners and/or aspirin?* YES NO *(If yes, list below name of medication with prescribing Dr.'s name and phone number)*

_____ _____

List all other medications and dose below:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES: _____

PREVIOUS SURGERIES: _____

_____

DO YOU SEE A CARDIOLOGIST? YES NO Who? _____

REFERRING PHYSICIAN _____ PHONE _____

University Gastroenterology
Patient Registration

PATIENT NUMBER _____

PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____

PREFERRED NAME _____

MARTIAL STATUS
❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED

EMPLOYMENT STATUS
❑ EMPLOYED ❑ RETIRED ❑ FULL TIME STUDENT ❑ OTHER

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME (_____) _____ WORK (_____) _____

CELL (_____) _____

FAMILY DOCTOR _____

NAME OF REFERRING PHYSICIAN _____

EMPLOYER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ ID # _____

SECONDARY INSURANCE _____ CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ ID # _____

EMERGENCY CONTACT

RELATIONSHIP _____ SEX _____

FIRST NAME _____ LAST NAME _____

HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

CONTACT INFORMATION

PHARMACY _____ PHARMACY NUMBER (_____) _____

University Gastroenterology will leave confidential messages on your answering machine, with a family member or other individual answering the phone when you are not home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you to call back.

Please contact me as follows:

HOME TELEPHONE (_____) _____
☐ OK to leave messages with healthcare information
☐ Leave message with call back number only
☐ Do NOT leave messages

WORK TELEPHONE (_____) _____
☐ OK to leave messages with healthcare information
☐ Leave message with call back number only
☐ Do NOT leave messages
☐ Retired or not working

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party authomated outreach and messaging system to use my contact information, the name of my care provider, and limited information, for the purpose of notifying me of balances due, when necessary.

LIST NAME OF INDIVIDUALS YOU AUTHORIZE US TO SPEAK WITH REGARDING YOUR HEALTHCARE

☐ NONE
☐ Spouse _____
☐ CHILD _____
☐ CHILD _____

If we are unable to reach you by any other means, we sill send information through the U.S. Postal Service to your home address.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I Hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly tot he Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____

_____ _____

SIGNATURE (Patient or Parent if Minor) DATE

University Gastroenterology
Payment Policy

We are committed to providing you with quality and affordable healthcare. Please read the below and ask any questions you may have, and sign in the space provided.

1. Insurance Plans. We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross Blue Shield of Tennessee, Blue Care, Bowater, Americhoice, Humana, Champus-military only, CIGNA, The Initial Group, PHCS, Preferred Health Partnership (PHP), and United Healthcare. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding our coverage.

2. Co-payments. All co-payments must be paid a the time of service. This arrangement is part of your contract with you insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.

3. Referrals. Many patients are now required to obtain referrals or authorizations from their primary care physician (PCP) before receiving treatment from a specialist. It is important that you obtain this from your PCP before coming in for your appointment. Our fax # is 865-305-6576.

4. Non-Covered Services. Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit with your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item.

5. Proof of Insurance. All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once every year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim. 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. We will also need to have a copy of your new insurance card.

6. Claim Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any moneys owed after we have received payment from Medicare and/or a secondary policy that you might have.

7. Non-payment. If your account is over 90 days past due, you will receive a letter from our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. HIPAA. A copy of the UPA Notice of Information Practices has been made available to me. I understand that this notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by visiting www.utmedicalcenter.org.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient signature _____ Date _____

A copy of this can be provided to you upon request.

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Please read and sign in space provided below. A copy of this can be provided to you upon request.

We recognize the need for a definite understanding between the patient and the doctor concerning health care and the financial arrangements for this medical care. Our commitment is to provide the very best health care for our patients while recognizing the need to limit services to only those that are necessary for each patient.

Our fees reflect the time spent by the doctor with you, the patient, the specialized nature of the doctor's training, and the individual diagnostic studies performed. Our fees are comparable to other similarly trained specialists in the community.

If you are scheduling a ***screening colonoscopy,*** or find that you are in need of one in the future, please understand that the pre-certification we get from your insurance company is only a guideline that you can use. If our physician finds that you need a polyp removed during the procedure he will remove it. In this case, this will change your screening to a diagnostic procedure which could **possibly** cause your insurance company to pay less than originally stated. Of course, the fees for care during a specialized procedure or hospitalization may be paid on any mutually agreeable basis. Please contact your insurance company with any additional questions you might have concerning your procedure.

Please let us know if you are having any particular financial problem - you will find us understanding and patient.

I have read and understand the above.

Signature_____ Date _____