



DIGESTIVE DISEASE ASSOCIATES

DIRECT ACCESS SCREENING COLONOSCOPY INSTRUCTIONS

Please complete all forms. Attach any additional documents and fax, mail or deliver to the appropriate office location below:

Catonsville:

700 Geipe Road, Suite 230
Catonsville, MD 21228
Phone: 410-247-7500
Fax: 410-247-4227

Columbia:

10710 Charter Drive, Suite 110
Columbia, MD 21044
Phone: 410-992-9797
Fax: 410-730-0942

Thank you for contacting our office for a Direct Access Screening Colonoscopy. This process will potentially allow you to have your procedure without first being seen by one of our gastroenterologists. Please be aware this program is for individuals without any gastrointestinal symptoms with a medical history that meets the guidelines for the program.

- 1. A copy of your insurance card(s), front and back.**
- 2. A copy of your referral from your insurance carrier, if required by your insurance policy.**
- 3. A copy of your most recent history and physical or office visit notes from your primary care physician (PCP) and/or a copy of the office notes from your referring physician. Your PCP can also fax the information to our office.**

Upon receipt of your documents, a physician will evaluate your medical information to ensure you are a candidate for a Direct Access Screening Colonoscopy. Our staff will contact you within 10-14 days to schedule your procedure, or if you do not qualify, schedule your office visit. If you do not receive a call in 10-14 days, please call our office.

Confirmation of your scheduled procedure (or appointment) as well as instructions for your procedure will be mailed to you. Dietary and bowel preparation instructions will be included.

**Thank you for selecting Digestive Disease Associates for your medical care.
If you have any questions concerning your procedure or the process, please contact us!**



DIGESTIVE DISEASE ASSOCIATES

DIRECT ACCESS SCREENING CHECKLIST

PATIENT NAME

DOB

REFERRING PHYSICIAN

GI PHYSICIAN PREFERENCE

Please answer the following questions to assess your eligibility for a Direct Access Screening Colonoscopy.

If you answer yes to any of these questions, you may need an office visit before your procedure is scheduled.

Yes No

1. Are you over 65?
2. Do you weigh more than 315 lbs and have a BMI above 45?
Height _____ Weight _____ BMI _____
3. Have you had a change in your medical history in the last year?
IF YES, PLEASE PROVIDE DATE (MONTH AND YEAR).
 Heart attack _____ Irregular heartbeat _____
 Coronary artery stent replacement _____ Stroke _____ Seizure _____
4. Have you ever seen a cardiologist (heart doctor)?
If yes, what is the doctor's name? _____
5. Do you have any current gastrointestinal symptoms that need to be addressed with the physician prior to the procedure? (***This includes heartburn, abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia.***)
6. Are you currently on dialysis, have a defibrillator, pacemaker, artificial heart valve, breathing issue requiring home oxygen, or being monitored by a respiratory doctor?
(Please circle all that apply.)
7. Are you on any blood thinners other than aspirin?
8. Will you have any contraindications (problems) stopping any of your medications 5-7 days prior to your procedure? (***This includes Aspirin, Ibuprofen, Motrin, Advil, or any other non-steroidal medication.***)
9. Are you a diabetic?
If yes, do you have an insulin pump? Yes No



DIGESTIVE DISEASE ASSOCIATES

PATIENT DEMOGRAPHICS AND INSURANCE FORM

TREATING DOCTOR ABERNATHY ALEX ANDORSKY BANEGURA CROSSE JOY P. KIM
 (PLEASE CHECK) MOUSSAIDE NARAYEN RAVENDHRAN SALAS SARDANA SOLOMON VAN DEN BROEK

TODAY'S DATE	<input type="checkbox"/> DR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> MISS <input type="checkbox"/> MR.	FIRST NAME	MIDDLE	LAST	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS		CITY		STATE	ZIP	
WHEN WE CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT, SHOULD WE CONTACT YOUR? <input type="checkbox"/> HOME PHONE <input type="checkbox"/> CELL PHONE			HOME PHONE	WORK PHONE		
			CELL PHONE	EMAIL ADDRESS		
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> DECLINED <input type="checkbox"/> OTHER _____				
RACE <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> DECLINED <input type="checkbox"/> OTHER _____				PRIMARY LANGUAGE		
EMPLOYER			IN CASE OF EMERGENCY, NOTIFY	DAYTIME PHONE		
PERSON FINANCIALLY RESPONSIBLE <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____	IF DIFFERENT THAN PATIENT: NAME				PHONE NUMBER	
				ADDRESS		
PRIMARY INSURANCE INFORMATION				SECONDARY INSURANCE INFORMATION		
COMPANY NAME		PHONE NUMBER		COMPANY NAME		PHONE NUMBER
POLICY NUMBER		GROUP NUMBER		POLICY NUMBER		GROUP NUMBER
NAME OF POLICY HOLDER				NAME OF POLICY HOLDER		
EMPLOYER				EMPLOYER		
POLICY HOLDER'S DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO INSURED		POLICY HOLDER'S DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO INSURED
REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION						
REFERRING PHYSICIAN (RP)			PRIMARY CARE PHYSICIAN (PCP)			
PHONE NUMBER			PHONE NUMBER			
HOW WERE YOU REFERRED TO OUR PRACTICE? <input type="checkbox"/> PRIMARY CARE PHYSICIAN <input type="checkbox"/> OTHER PHYSICIAN <input type="checkbox"/> OUR WEBSITE <input type="checkbox"/> FRIEND <input type="checkbox"/> RELATIVE <input type="checkbox"/> OTHER _____						
PHARMACY INFORMATION						
PREFERRED PHARMACY				PHONE NUMBER		
ADDRESS						



DIGESTIVE DISEASE ASSOCIATES

MEDICAL HISTORY FORM

PATIENT NAME _____

DOB _____

REFERRING PHYSICIAN _____

PRIMARY CARE PHYSICIAN _____

INSTRUCTIONS: This questionnaire will assist us in understanding your medical condition. Please answer all the questions fully and print legibly. If you are uncertain about any questions, please use a question mark (?)

CHECK ONE OR MORE OF THE FOLLOWING REASONS THAT APPLY:

NONE Are you constipated? Yes No Average # of bowel movements per day/week: ____/____

SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET
<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> Change in bowel habits		<input type="checkbox"/> Incontinence of stool	
<input type="checkbox"/> Abnormal CT scan or ultrasound		<input type="checkbox"/> Chest pain		<input type="checkbox"/> Nausea and/or vomiting	
<input type="checkbox"/> Abnormal liver enzymes		<input type="checkbox"/> Constipation		<input type="checkbox"/> Painful swallowing	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Black, tarry stools		<input type="checkbox"/> Difficulty Swallowing		<input type="checkbox"/> Vomiting blood	
<input type="checkbox"/> Bloating/Gas		<input type="checkbox"/> Excessive Belching		<input type="checkbox"/> Weight loss	
<input type="checkbox"/> Blood in a stool on test		<input type="checkbox"/> Heartburn / GERD		<input type="checkbox"/> Other	
		<input type="checkbox"/> Hepatitis / Jaundice			

PAST MEDICAL ILLNESSES Check if you have a history of any of the following. Please check all that apply.

NONE

GASTROINTESTINAL			
<input type="checkbox"/> Barrett's esophagus	<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Fatty liver	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> H. Pylori	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Irritable bowel (IBS)	<input type="checkbox"/> Other _____
CARDIOVASCULAR			
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Coronary artery diseases	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Extra heart beats (PVC)	<input type="checkbox"/> Slow heart beat	
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Supraventricular tachycardia	
PULMONARY		ENDOCRINE	NEUROPSYCHIATRIC
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> I use CPAP machine	<input type="checkbox"/> Other _____	<input type="checkbox"/> Insulin pump	<input type="checkbox"/> TIA (mini-stroke)
<input type="checkbox"/> Emphysema (COPD)		<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
GENITOURINARY	HEMATOLOGIC		ONCOLOGY
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Other _____		Any malignant tumors not previously mentioned _____
<input type="checkbox"/> Renal failure	<input type="checkbox"/> Clotting disorders		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Low platelets		

DIAGNOSTIC TESTS Check the boxes below if you have had any of the following tests and indicate the date.

NONE

Date _____
 Barium enema _____
 Colonoscopy _____
 CT scan (abdomen/pelvis) _____
 Flexible sigmoidoscopy _____

Date _____
 MRI (abdomen/pelvis) _____
 Ultrasound (abdomen) _____
 Upper Endoscopy (EGD) _____
 Upper GI Series _____

PAST SURGICAL HISTORY Check the boxes below if you have had any of the following surgeries and indicate the year.

NONE

Year _____
 Appendix surgery _____
 Back/spine surgery _____
 Bariatric surgery _____
 Breast surgery _____
 Heart bypass _____
 Gall bladder removal _____

Year _____
 Heart catheterization _____
 Heart defibrillator _____
 Heart pacemaker _____
 Heart stenting _____
 Heart valve replacement _____
 Hernia repair _____

Year _____
 Hysterectomy _____
 Neck surgery _____
 Rectal surgery _____
 Other _____

ALLERGIES List all allergies, including medication allergies (also include over-the-counter medications) Indicate reaction to allergy (ie. rash, hives, shock, etc.) and if hospitalized for treatment.

NONE

Allergy	Reaction	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check all statements which apply

- I have had prior difficulties with anesthesia I require antibiotics prior to surgery
 I have a latex allergy I have an allergy to Iodine or IV Contrast

MEDICATION LIST List medication names, doses and how often taken. Include "over-the-counter" medications.

NONE

Medication Name	Dose	Frequency taken (eg: once per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If on a blood thinner, please check Coumadin Warfarin Plavix Pradaxa Other _____

FAMILY HISTORY NONE

Relationship/Age Diagnosed	Relationship/Age Diagnosed	Relationship/Age Diagnosed
<input type="checkbox"/> Breast cancer _____	<input type="checkbox"/> Pancreatic cancer _____	<input type="checkbox"/> Esophageal cancer _____
<input type="checkbox"/> Liver cancer _____	<input type="checkbox"/> Colon polyps _____	<input type="checkbox"/> Ulcerative colitis _____
<input type="checkbox"/> Celiac disease _____	<input type="checkbox"/> Stomach cancer _____	<input type="checkbox"/> Kidney cancer _____
<input type="checkbox"/> Ovarian cancer _____	<input type="checkbox"/> Crohn's disease _____	<input type="checkbox"/> Uterine cancer _____
<input type="checkbox"/> Colon cancer _____	<input type="checkbox"/> Thyroid cancer _____	

SIGNATURE _____

DATE _____



DIGESTIVE DISEASE ASSOCIATES

FINANCIAL POLICY

FOR PATIENTS WITH INSURANCE: Co-payments, coinsurance and/or deductibles are the responsibility of the patient or responsible party and due at the time of service. It is the patient's responsibility to obtain a written referral and authorization if their insurance carrier requires the same. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.

FOR PATIENTS WITHOUT INSURANCE: I understand that payment for services rendered by DDA is due and payable in full at the time services are rendered, unless prior arrangements have been made with an employee of DDA.

IN THE EVENT: The Patient submits payment by check and that check is returned for any reason by the Bank, DDA will add \$30.00 to the balance owed by the Patient or Responsible Party.

NO STATEMENT BY AN EMPLOYEE or agent of DDA will contradict, void, or nullify this agreement, nor shall the patient rely on any statements or opinions made by DDA that Patient's insurance carrier will pay the bill.

PAYMENTS: Unless other arrangements are approved by DDA in writing, the balance on your statement is due and payable when the statement is issued, and past due if payment is not received within 60 days after adjudication by your insurance carrier.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the steps necessary to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collection costs that are incurred, including attorney fees and court costs, if applicable. Any balance unpaid after 60 days from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney and/or collection agency, if DDA has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and that your account is delinquent with DDA will become a matter of public record.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I give my consent for treatment and authorize the release of clinical information to other medical professionals who have need of such use for the provision of my care. I hereby authorize DDA to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf. Authorization is hereby given to DDA to submit all claims directly to my insurance company on my behalf and authorize my insurance carrier to forward payment directly to DDA.

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide information below on how we should contact you.)

I hereby authorize DDA to communicate information regarding my evaluation, diagnosis, treatment and billing to/with:

- My spouse/family member/other _____
NAME INITIALS
- My spouse/family member/other _____
NAME INITIALS
- If, when calling, we reach an answering machine or voicemail message, may we leave a message? Y N _____
INITIALS

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I authorize DDA to obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of my treatment.

AUTHORIZATION AND ACKNOWLEDGMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Digestive Disease Associates as described above, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested in the section titled Confidential Communication of Personal Health Information, that I give authorization to DDA to obtain my Medication History as indicated above and that I have received a copy of the Digestive Disease Associates Notice of Privacy Practices.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

IF RESPONSIBLE PARTY, PLEASE PRINT NAME

RELATIONSHIP TO PATIENT



DIGESTIVE DISEASE ASSOCIATES

APPOINTMENT CANCELLATION / NO-SHOW POLICY

Digestive Disease Associates is privileged to provide medical and endoscopic treatment for our patients. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's needs for office visits and procedures in a timely manner. This requires careful planning and coordination amongst many individuals in our office. We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment or procedure without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, we have developed this policy regarding failure to keep appointments or canceled appointments without adequate notice. This policy will also apply to scheduled procedures, but the monetary consequences will be greater. We respectfully request your understanding and agreement to our policy as is stated below.

OFFICE VISITS

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than **24 HOURS** in advance of their appointment will be charged a fee of \$50.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday. If an established patient fails to keep three appointments or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

PROCEDURES

Any patient who fails to keep an appointment for a procedure (upper endoscopy, colonoscopy, flexible sigmoidoscopy, endoscopic retrograde cholangiopancreatography) or remicade infusion; or who cancels or reschedules an appointment less than **48 HOURS** in advance of their procedure or infusion will be required to pay \$100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Thursday.

If an established patient fails to keep two appointments or fails to give adequate notice on two occasions, their primary care physician will be notified, and the practice will have the right to dismiss that patient from the practice.

FEES

All fees charged by Digestive Disease Associates pursuant to this No-Show / Cancellation Policy are not payable by your insurance company.

All fees are payable on or at your next office appointment with your Digestive Disease Associates physician or within 30 days of receipt of billing statement from Digestive Disease Associates for that fee, whichever is earlier.

Please remember that it is your responsibility to make certain that we have updated and/or accurate phone numbers and addresses so that we may contact you promptly.

Thank you for your consideration and understanding of our policy.

PATIENT SIGNATURE

DATE



DIGESTIVE DISEASE ASSOCIATES

DRIVER RESPONSIBILITIES

As our patient, your safety is of utmost importance to us. You will be receiving intravenous sedation during your endoscopy procedure. Although the medications wear off gradually, you will still be under the effects of them when you leave the procedure. For example, your reflexes and your thinking may be slower than usual even though you will be awake when you are discharged. Because of this, we have strict guidelines for you to follow. **Failure to follow these guidelines will result in the rescheduling of your procedure, even if you have followed the preparation instructions.**

Read the following information and share it with your escort/driver prior to the date of your procedure:

1. You must have a responsible adult escort/driver, age 18 years or older, check in with you. This person must remain in the building throughout your procedure and recovery. Ask your escort/driver NOT to make appointments or plans for the time you are scheduled at the endoscopy center. **DO NOT** plan to phone your driver for pick up.
2. If you take Public transportation, such as a city bus, taxi, uber, etc. you must have a responsible escort/driver check in with you and remain in the building throughout your procedure.
3. Your escort/driver **MUST** check in with you and speak with the endoscopy center office staff when you arrive. If your escort/driver does not check in with you, your procedure will need to be rescheduled. If you have questions about this, contact our office at 410-247-7500.
4. The visit will take approximately two to three hours, from admission through discharge. The amount of time could be less or more, depending on unforeseen circumstances.
5. Your escort/driver must plan to drive you home immediately after discharge. The doctor may recommend that you eat sparingly, or not at all, in the hours immediately following the procedure. Please drink lots of fluid and eat soft, easily digestible foods which won't irritate your colon.
6. All patients receive written discharge instructions and information regarding their procedure. While your physician will talk with you briefly following your procedure, you may not remember specific conversation details due to the medications you received.
7. As authorized by you prior to your procedure, your physician may speak with your escort/driver regarding the findings of your exam and plan for your care while you are still in the recovery room.

PATIENT SIGNATURE

DATE

PRINTED NAME

DATE OF BIRTH