Important Information About Your Colonoscopy

Thank you for choosing Holston Medical Group Gastroenterology. As your health partner for life, we want to take this time to inform you about the **TYPE** of colonoscopy you may have.

Below are the **THREE** (3) categories you may fall into, depending on why you are undergoing the procedure.

1. <u>Preventive/Screening - Screening Benefits</u>

- Patient is 45 years of age or older. You may need to call your insurance to check if it is covered.
- Patient has NO gastrointestinal symptom(s) and/or relevant diagnosis.
- Patient has NO **PERSONAL** history of colon cancer, polyps, and/or gastrointestinal disease.
- Patient may have a family history of gastrointestinal symptom(s) and/or relevant diagnosis.
- Can be performed once every **10** years aged 45-75

  - ✓ *Patients with a **history of colon polyp(s)** are **NOT** recommended for a **SCREENING** colonoscopy.
  - ✓ **If a polyp is found during a preventive/screening colonoscopy, your insurance may not pay at 100%. Please check with your insurance company to check YOUR policy coverage.**

2. <u>Diagnostic/Therapeutic – Diagnostic Benefits</u>

- Patient has a gastrointestinal symptom, polyps and or disease.
  - o Example: Rectal bleeding, anemia, diarrhea, change in bowel habits, etc.
  - ✓ **Out-of-pocket expenses may apply to deductibles and co-insurance.**

3. <u>Surveillance – Diagnostic Benefits</u>

- Can be performed at varying ages and intervals based on the patient's Personal history of colon cancer, polyps, and/or gastrointestinal disease.
- Patients with a history of colon polyp(s) are **NOT** recommended for a **SCREENING** colonoscopy.
  - ✓ **Out-of-pocket expenses may apply to deductibles and co-insurance.**

<u>Who will bill me?</u>

You may receive bills from separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory.

<u>Can the physician change, add, or delete my diagnosis so that I can be considered for a colon screening?</u>

No. The patient encounter is documented as a medical record from the information you have provided and an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

______________________________________ ______________________

Signature **Date**

Dallas N. Shone, MD | Lawrence Bailey, MD | James Swenson, MD | Erika Grigg, MD | Jennifer Phemister MD
Ashlee Fleming, NP | Jacquelyn Baker, NP | Amanda Campbell, NP | Rhonda Ragsdale, NP

Important Information About Your Colonoscopy

How will I know what my insurance will cover?

We encourage you to call your insurance carrier and verify the benefits and coverage.

Here are a few tips or questions you can ask your insurance company. You must give the insurance representative your preoperative CPT and Diagnosis codes.

1. Is the preoperative procedure ____________ and diagnosis _____________ covered under my policy? ☐Yes ☐ No
2. Will the diagnosis code ____________ be processed as preventative, surveillance, or diagnostic, and what are my benefits for that service?
3. What is my deductible: ___________
4. What is my coinsurance responsibility? _________________
5. Is the Facility ____ in Network: ☐Yes ☐ No
6. Are there age and /or frequency limits for my colonoscopy? (one every ten years over the age of 50 for screening, one every one, **three**, or **five** years for a personal history of polyps)
   Yes, specify____
   No____
7. If the physician removes a polyp, will this change my out-of-pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit: more out-of-pocket expenses. Insurance companies vary on this policy) ☐Yes ☐ No

Get the Representative's Name: _____________________ Call Reference #: __________________

Date: __________________

If you have any questions or concerns, please call our office at 423-578-1595

Welcome to our office

Where did you hear about us?

❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) ________________________________

OFFICE USE ONLY
Physician:____________________
Approved by:____________________
Date:____________________

NEW PATIENT INFORMATION (Complete if different from billing party)

Name____
First Middle Last

Address____

City______________________ State__________ Country ________Zip__________ Phone # (____)__________

Birthdate______________ Sex M or F Race____________________ Marital Status S M W D

Social Security #______________________ Employer______________________

Address of Employer______________________ Work Phone #______________________

May we contact you at work? Y N By E-Mail Y N E-Mail Address ______________________

Emergency Contact Name______________________ Emerg. Phone # (____)__________

Relationship to billing party______________________

Guarantor/Responsible Party

Name____
First Middle Last

Address____

City______________________ State__________ Zip__________ Phone #__________

Birthdate______________________ Sex M or F Marital Status S M W D

Social Security #______________________ Driver's License #______________________

Place of employment______________________ Work Phone #______________________

OTHER INFORMATION

Name and address of nearest relative not living with you______________________

Address______________ City______________ State__________ Zip__________ Phone #__________

If you are currently under another physician's care, please list:

Name____

Address______________________ City______________ State__________ Zip__________

Whom may we thank for referring you to us?______________________

INSURANCE

1. Primary Insurance Company Name______________________

Group #______________________ Policy Member #______________________

Subscriber Name______________ Subscriber Birthdate______________ Sex M or F Social Security #__________

Subscriber Employer and Address______________________

2. Secondary/Supplemental Insurance Name______________________

Group #______________________ Policy/Member #______________________

Subscriber Name______________ Subscriber Birthdate______________ Sex M or F Social Security #__________

Subscriber Employer and Address______________________

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.

By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date______________________ Signature____

Rev. 10-2008

NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment **may be charged a fee** for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

______________________________	______________________	______________________
Please Print Patient Name	Date of Birth	Account Number

______________________________	______________________________
Please Sign Authorized Representative	Relationship to Patient
______________________________	______________________________
Witness	Date

MRN:____________________________

DATE RECEIVED: ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

____ ____________________
Print Patient Name | Patient Date of Birth

____ ____________________
Patient Signature (if applicable) | Date

____ ____________________
Authorized Representative Signature | Relationship to Patient

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I understand that my protected health information will only be verbally communicated to those individuals listed below. I also understand this may include sensitive information, including but not limited to: Urine Drug Screen results, laboratory test results, or information discussed during an office visit. Those individuals I list below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them. List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:

____ ____________________
Employee Signature | Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ت ب ك م ر مدي مع تحدث ال ل ب ط ت أن رجى ي ،ترجمة ال أو غة ل ال خدمات ى إل حاجة ب ذ ت ك إذا : ب اه ت ان .

Revised: 10/12/2022

Name:________________________________ **MRN:**____________________ **Date :**_________________

HMG Gastroenterology-New Patient History Form

Please list reason(s) you are here for evaluation: _______________________________________

Occupation or job: ____________________________Do you follow a specific diet?____________

Please circle marital status: single married widowed divorced separated

Do you have specific religious beliefs that may affect medical decisions/treatment?_______________

Past Medical History: please circle if you have ever had any of the following conditions:

diabetes	high blood pressure	high cholesterol	COPD/emphysema or asthma	colon polyps
heart disease	thyroid disease	stroke	peripheral vascular disease	rectal bleeding
anemia	acid reflux	gout	difficulty swallowing	jaundice
sleep apnea	arthritis	kidney disease	anxiety or depression	ulcer
seizures	bleeding disorder	hepatitis	Cancer: type: _________________________	

Please list any other medical problems you have: ____

Have you had an endoscopy (EGD) YES or No Years ago_______ **or colonoscopy YES or NO Years ago**_______

Do you take anti-inflammatory medications or blood thinners? __________________________________

Please list surgeries you have had, and year performed: _______________________________________

Family History-Please list any important medical history involving your family member:

My father's medical problems include: ____

My mother's medical problems include: ____

I have ____brother(s). Medical problems include: ____

I have ____sister(s). Medical problems include: ____

I have ____children. Medical problems include: ____

Please list any other important information regarding family member's medical history:

Is there a family history of colon polyps? ______If yes, who? ______________________________________

Is there a family history of colon cancer? ______If yes, who? ______________________________________

Do you currently smoke cigarettes? ________If yes, how many packs per day? ___________**Vape?**___________

--How many years have you/did you smoke? ____

Do you consume alcohol? ___________If yes, how much? ___________________________________

Do you use marijuana, recreational, or street drugs? _________if yes, please explain: _________________

Best phone number to contact you: ____________________**Can we leave a message**? _____________________

Pharmacy: ______________________________________**Drug Allergies**: _________________________

MRN: ______________________________

Date: ______________________________

Communicating with Your Specialist

Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, Follow my Health. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your provider's telephone message will direct you on how to contact the HMG Physician on Call.

Autodialed Calls/Appointment Reminders

I understand HMG may contact me by auto-dialed calls and/or text messages, to the number I provided, to remind me of my scheduled appointment(s) or with information of available health services. If the telephone number I have provided is changed or re-assigned to another person, I will promptly notify HMG.

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 2 business days for all refill requests before checking with your pharmacy.

Sample medication or vouchers will only be distributed during normal business hours.

If requesting controlled medication refills, you may be required to have an office visit.

Printed Name: ______________________________

Signature: ______________________________ **Date:** ________________

Witness: ______________________________ **Date:** ________________

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, religion, sex (including pregnancy or termination of pregnancy), gender identity (including gender expression), sexual orientation, disability, citizenship, marital status, family/parental status, ability to pay, political beliefs, or veteran status.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.

ان ت باه :إذا ك نت ب حاجة إل ى خدمات ال ل غة أو ال ترجمة، ي رجى أن ت ط لب ال تحدث مع مدي ر م ك تب.

주의: 언어 또는 번역 서비스를 해야 하는 경우 문의 하시기 바랍니다 사무실 매니저와 얘기를

注意：注意：如果您需要語言或翻譯服務，請與辦公室經理聯繫。

Patient Financial Policy

Holston Medical Group believes that part of good healthcare is establishing and communicating a financial policy to our patients. We are dedicated to providing the best care for you, and we want you to understand our financial policy.

1. **INSURANCE**
   We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage.

2. **CO-PAYMENTS AND DEDUCTIBLES**
   All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **NON-COVERED SERVICES**
   Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. **PROOF OF INSURANCE**
   All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. ***We ask that you be prepared to provide a copy of your current insurance card(s) at each visit to ensure we can properly file your claim.***

5. **SELF-PAY ACCOUNTS**
   Self-pay accounts refer to:

   - Patients without insurance coverage
   - Patients covered by insurance plans in which the office does not participate
   - Patients without an insurance card on file with us

   Your responsibility is always to know if our office participates in your plan. If there is a discrepancy in our information, we will always consider a patient self-pay unless proven otherwise. Self-pay patients will be required to pay at the time of service. The payment requested may be a minimal estimated amount. If the level of service is more complex or additional services are provided, you may receive an additional billing statement. Self-Pay accounts will receive a 25% discount on all qualifying services.

6. **SURGERY PATIENTS**
   You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information provided by your insurance company.

7. **HIGH-DEDUCTIBLE PLANS**
Under these plans, your insurance company will provide a discount on our billed charges, but you are responsible for the entire amount due until you meet your deductible.

8. **RETURNED CHECKS**
A returned check will incur a $40.00 service charge.

9. **CREDIT REFUNDS**
If there is an overpayment on your account, we will refund any credit balances due to you after the overpayment credit is applied to any outstanding account balance(s).

10. **FORMS FEES**
Forms, except those involving worker's compensation cases, will be billed at the rates listed below. Payment is expected in full at the time of pick-up or before any electronic transmission of forms.

    Simple Forms (completed within 2 business days)
    Examples of simple forms: handicap tag/sticker, work re-entry form, immunization, medication, sports, concussion clearance, WIC, home bound status short form, disability short form, bank loan form, foster parent health form, college & camp forms.
    Fee if completed during an office visit: No Charge
    Fee if completed after an office visit: $5.00 per form

    Complex Forms (completed within 10 business days)
    Examples of complex forms: FMLA (per illness per year), disability long form, home bound status long form.
    Fee: $25.00 per form

11. **PAYMENTS**
Payment is expected at the time of your visit or within 30 days upon receipt of a statement from our billing office. We accept cash, check, money order, debit, credit, or health savings accounts. You may also make a payment online through our billing portal.

12. **DELINQUENT ACCOUNTS**
If any balance on your account is over 120 days past due, your account will be in default and automatically referred to an outside collection agency. You will be responsible for any additional costs incurred during the collections process. If default occurs, you may also be blocked from making future non-emergency-related appointments until your account is made current.

13. **FINANCIAL DISMISSAL**
Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from the date of dismissal.

14. **BILLING QUESTIONS**
We will be happy to help you resolve your balance and can be reached at (423) 578-1802, Monday – Friday 8:00 AM – 5:00 PM ET.

MRN#: ________________________

Date Rcvd: _____________________

Patient Financial Policy

Holston Medical Group believes that part of good healthcare is establishing and communicating a financial policy to our patients. We are dedicated to providing the best care for you, and we want you to understand our financial policy.

I have read, understand, and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and any charges older than 30 days from the service date, are my responsibility.

I agree to receive emails and text messages from Holston Medical Group and its affiliates regarding appointment reminders, balance reminders, or other account or health-related messaging. I also understand that I may opt-out of these communications anytime.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

________________	________________________________	__________________________
Date	**Signature**	**Printed Name**