



Your Procedure Appointment

Phone: (336) 448-2427*

Fax: (336) 714-3565

*Also used for after hours emergencies

WELCOME!

Thank you for choosing Gastroenterology Associates of the Piedmont, P.A. Each of our outpatient endoscopy centers are owned and operated by the physicians of Gastroenterology Associates of the Piedmont, P.A. Our physicians maintain board certifications in gastroenterology to perform endoscopic procedures.

PAPERWORK:

If you haven't already, please review the attached documents, sign where necessary, and return to GAP along with a copy of both sides of your insurance card(s) using one of the methods you see below. This eliminates unnecessary wait time during check-in and enables us to complete the necessary prior-authorization requirements to ensure the maximum payable benefit from your insurance.

- Fax to **(336) 714-3565**
- Drop off at or mail to one of the following locations:
 - ☐ **Salem Endoscopy Center**
875 Bethesda Rd.
Winston-Salem, NC 27103
 - ☐ **Piedmont Endoscopy Center**
1901 S. Hawthorne Rd. Suite 308
Winston-Salem, NC 27103

APPOINTMENT TIME:

Your arrival time is 45 minutes prior to your appointment time. This allows us to complete the check-in process, review your health history with our staff, and undergo an evaluation for anesthesia prior to your procedure. Please be aware that we may contact you in the days leading up to your procedure, as your arrival time may be subject to change.

TRANSPORTATION POLICY:

For your safety, it is our policy that a patient scheduled for a procedure with sedation will have an adult (age 18+) available to accompany them home. We require that the accompanying adult arrive with you to your appointment and agree to drive you home afterwards.

Please note that:

- It is your decision as to whether your procedure results will be shared with your driver.
- You may not drive for 8 hours after receiving sedation.
- Taking a taxi, bus, or other ride service (e.g. Uber) is not an acceptable form of transportation unless you are accompanied by an adult acquaintance who will ensure you arrive home safely.

If after scheduling you are unable to secure an adult to accompany you, you are responsible for rescheduling the procedure for a time that you are able to comply with this policy.

QUESTIONS?

Feel free to give us a call at (336) 448-2427 if you have health concerns or questions about your appointment. If you have been assigned a patient advisor to assist with your prep, they can be reached at (800) 349-0285.



Patient Authorization and Consent Form

Appointments and Procedures During COVID-19 Pandemic

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. As a result, many hospitals, doctor's offices and surgery centers were asked to put a hold on all elective and non-urgent clinical appointments, procedures and surgeries. On May 1, 2020, the NC Department of Health and Human Services lifted these holds in the state of North Carolina.

We will do all we can to assure that you are protected while at our facility. However, even with proper use of PPE and disinfection methods, there is still a risk of exposure at these types of appointments. This risk includes, but is not limited to exposure to other patients, healthcare staff, and healthcare facilities.

INFORMATION ABOUT COVID-19

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials. However, there are still risks of being infected with COVID-19.

I understand that exposure to COVID-19 may result in a COVID-19 diagnosis, which may result in a quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Other risks are not yet known.

I understand that if I have one or more of the following conditions, I may have a higher chance for 1) getting COVID-19 and 2) complications or health problems if I get COVID-19, which may be serious.

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

EXPOSURE STATUS

By signing this form, I attest that:

- I have not tested positive for COVID-19 in the last 14 days,
- I am not awaiting the results of a pending COVID-19 test,
- I have not had any known exposure to anyone who has tested positive for COVID-19 in the last 14 days, and
- I have answered the questions regarding my symptoms (or lack of symptoms) truthfully.

My appointment may be rescheduled if my provider believes I pose a risk of exposing others to COVID-19. I will report it to GAP if I test positive following my visit so they can take additional steps to prevent the spread.

CONSENT

I understand the risks related to potential exposure of COVID-19 as provided to me on this consent form. By signing below, I agree that staff/doctor has discussed the facts on this form with me, that I have had a chance to ask questions, that all of my questions have been answered, and that no one has given me any guarantee.

I understand that I have the option to reschedule my appointment for a later date, if desired. GAP also offers video or telemedicine options for services that are eligible. I give my consent to proceed with my appointment for clinical services/procedure(s) as scheduled.

Signature of Patient (or Responsible Party)

Date

Relationship to Patient (if Responsible Party is not Patient)

07.20.2020



Financial Policy: Ambulatory Surgical Center

Billing Questions: (336) 714-1262

Monday – Friday from 8:00am to 5:00pm

1. Payment is due at the time of service, which may include copays, deductibles, coinsurance, and past due balances. Reimbursement for charges will vary depending on your insurance coverage. We must collect these balances as part of our contract with your insurance company; failure on our part to collect from patients can be considered fraud.
2. If a patient has insurance in which we do not participate, our office is happy to file the claim; however, the balance will be the responsibility of the patient if payment is not received from the insurance in a timely manner.
3. We accept payment by cash, checks, money orders, Visa, MasterCard and Discover. You will receive a statement for any remaining balance which is due upon receipt. A detailed statement is available upon request. Our office will charge a \$25 fee for all returned checks. Please contact our office for special payment arrangements.
4. We will submit insurance claims on your behalf. Information needed to process your claim with your insurance company should be received and verified prior to your appointment. Coverage for your procedure is determined by your contract with your insurance company. We recommend that you contact your insurance company before receiving services.
5. Patients will receive monthly statements for amounts that are the responsibility of the patient. If after several attempts have been made to collect an unpaid balance and there has been no response in the form of a payment on the balance due, any unpaid balances may be referred to an outside collection agency.
6. Your insurance may provide different coverage depending on the category of your procedure. Many insurance companies follow the guidelines for colonoscopy as defined by The U.S. Preventive Services Task Force (USPSTF).
 - a. A procedure is considered “**screening**” if the patient has no symptoms and no personal history of colon polyps.
 - b. A procedure is considered “**diagnostic**” if the patient has signs, symptoms, and/or polyp removal.
 - c. A procedure is considered “**surveillance**” if the patient has a personal history of colon polyps, colon cancer, or gastrointestinal disease.
 - d. A patient is considered “**average risk**” if he/she is without symptoms and has no personal history of colon polyps or colon cancer, no family history of colon cancer, and is being screened at 10-year intervals.
 - e. A patient is considered “**high risk**” if he/she has a personal history of colon polyps or colon cancer or a family history of colon cancer and are being screened at intervals less than every 10 years.
7. **Information for all Medicare patients:** Colorectal cancer screening tests are considered “preventative services” paid 100% by Medicare. However, if a polyp is removed during the course of the procedure, Medicare may interpret the test to be diagnostic, and may require that coinsurance or copays to be billed to the patient.
8. You may incur charges for the following services related to your procedure:
 - a. **Physician Fee** ⇒ The fee for the physician performing your procedure.
 - b. **Facility Fee** ⇒ The fee for the use of the facility for your procedure.
 - c. **Pathology Fee** ⇒ If a biopsy is required, you may incur a fee from *Pathologists Diagnostic Services*. For questions concerning your pathology bill, call (336) 999-8888.
 - d. **Anesthesia Fee** ⇒ Anesthesia services at GAP are provided by *Anesthesia Care Services* under fee for service contract. For questions concerning your anesthesia bill, call (888) 447-7220.
9. The primary CPT procedure code(s) used for filing a claim with your insurance company are Colonoscopy (45378) and Endoscopy (43235). Depending on procedure findings, your CPT code is subject to change.
10. If our endoscopy centers are considered non-participating or out of network with your insurance company, our physicians can also perform procedures at hospital-based facilities. This option may result in you having more out of pocket expense. We encourage you to contact your insurance company to verify participation and reimbursement status specific to your plan.
11. Depending on your insurance company, the location code associated with your procedure and facility charges can differ. Below are the specific location codes corresponding with the major insurance companies with which GAP is a network provider:
 - a. **Location 11 “Office Based”:** Aetna, Blue Cross and Blue Shield (except State Health Plan)
 - b. **Location 24 “Ambulatory Surgical Center/Outpatient”:** Cigna, Coventry, Medcost, Medicaid, Medicare, Medicare Advantage Plans, State Health Plan, Tricare, United Healthcare

By signing below, I agree that I have read and understand the policies above.

Patient Name (please print)

Date of Birth

Patient Signature

Today's Date



Patient Rights and Responsibilities

Page 1 of 2

Patient Rights – You have a right to:

This center is a physician owned facility. You may exercise the following rights without being subjected to discrimination or reprisal.

- Considerate, respectful, and safe care that is free from abuse or harassment.
- A discussion of your illness, what we can do about it, and the likely outcome of care.
- Know the names and roles of the people caring for you here.
- Receive respectful and effective pain management.
- Receive as much information to consent to or refuse a course of treatment or invasive procedure and to actively participate in decisions regarding your medical care. If desired, procedure consent forms may be reviewed prior to your appointment at www.gapgi.com.
- Involve your health care proxy or significant others in the decision making process for medical decisions.
- Reasonable continuity of care and to know in advance the time and location of an appointment as well as the doctor you are seeing.
- Full consideration of personal privacy and confidentiality of your medical information. Your written permission will be obtained prior to releasing any medical information. When we do release your information to others, we ask them to keep them confidential.
- Review your medical record and ask questions unless restricted by law.
- Know of any relationships with other parties that may influence your care.
- Know about rules that affect your care and about charges and payment methods. You have a right to receive and examine an explanation of your bill regardless of the source of payment.
- Change doctors within our practice or to an external doctor not in our practice.
- You have a right to develop a living will or healthcare power of attorney although these will not be honored in this facility. If an emergency occurs, EMS will be called and you will be transferred to the hospital.
- Voice your concerns, complaints, or problems with the care you receive by contacting our nurse manager or practice administrator at (336) 448-2427. If we are unable to satisfactorily address your complaint, you may contact:

NC Medical Board: 1.800.253.9653

AAAHHC (our accrediting agency): 1.847.853.6060 or www.aaahc.org

NC DHSR Complaint Intake Unit: <https://dhhs.state.nc.us/dhsr/ciu/complaintintake>

Patient Responsibilities – You agree to:

- Provide accurate and complete information concerning your symptoms, past history, current health status, and complete medication list.
- Make known whether you clearly comprehend your medical care and what is expected of you in the plan of care.
- Follow the treatment plan and care instructions given to you.
- Keep appointments and notify us if you are unable to do so.
- Accept responsibility for your actions if you refuse planned treatment or do not follow your doctor's orders.
- Accept financial responsibility for care received and pay promptly.
- Follow facility policies and procedures
- Be considerate of the rights of other patients and staff.
- Be respectful of your personal property and of others in the facility.
- Inform the staff of any discomfort or pain and patient safety issues.
- Share your values, beliefs, and traditions to help the staff provide appropriate care.
- Have an adult (age 18+) who will accompany you to any appointment where you will receive sedation and drive you home afterwards. You may not drive for 8 hours after receiving sedation. Taking a taxi, bus, or other ride service is not an acceptable form of transportation unless you are accompanied by an adult acquaintance who will ensure you arrive home safely.



Patient Rights and Responsibilities (continued)

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Notice of Nondiscrimination:

Gastroenterology Associates of the Piedmont, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance:

ATTENTION: Language assistance services are available free of charge to patients who do not speak English. Call (336) 448-2427.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (336) 448-2427.

Notice to Medicare Patients:

All issues, concerns, or complaints can be reported by contacting our nurse manager or practice administrator. If we are unable to address your concerns, you may contact the following for assistance.

Medicare Ombudsman

Web address: <https://medicare.com/administration/what-is-the-medicare-beneficiary-ombudsman/>

Phone: (800) 633-4227

TTY users call: (877) 486-2048

Advance Directives – Living Will or Health Care Power of Attorney Resources:

We do not honor living wills or Do Not Resuscitate Orders (DNR) at this facility due to the fact that a terminal, incurable, vegetative state is not anticipated in this outpatient setting. If you present to this center for a procedure with a living will or valid Do Not Resuscitate Order (DNR) or Out of Facility form and you have an emergency, we will start CPR and call 911 for emergency transport to the hospital. EMS will be informed of the Do Not Resuscitate Order or Living Will upon arrival.

For applicable state laws and sample forms for creating a living will or healthcare power of attorney, you may contact one of the following:

1. Caring Information Organization at 1.800.658.8886 for English or 1.877.658.8896 for other languages or www.caringinfo.org
2. NC DHHS Division of Aging and Adult Services at 1.800.662.8859 or www.ncdhhs.gov/aging/direct
3. Carolinas End of Life Care at 1.919.807.2162 or www.carolinasendoflifecare.org.

By signing below, I agree that I have read and understand the policies on pages 1 and 2.

Patient Name (please print)

Patient Signature

Today's Date



Pathology Disclosure Notice

During your procedure, we may remove a lesion or polyp and/or perform a tissue biopsy to determine if the samples are normal, pre-cancerous or cancerous.

These specimens will be referred to:

Pathologists Diagnostic Laboratory, PA:

630 Brookwood Business Park Dr.

Winston-Salem, NC 27105

Their team of experienced pathologists includes:

Dr. Bilal A. Ahmad

Dr. Nathan S. Cuka

Dr. Sarah Karram

Dr. Christopher R. Madden

Dr. Kelley O. Montoya

Dr. Elizabeth S. Norman

Dr. Danielle M. Rocchio

Dr. Emily Rostlund

Dr. N. Keith Sugg

Dr. Romulado V. Talento

Dr. Cullen A. Taylor

North Carolina law requires us to disclose to all patients the price we pay for these services. Currently, the fees per specimen are: CPT 88305 -- \$23, CPT 88312 -- \$25, CPT 88313 -- \$22 and CPT 88342 -- \$28. We will bill your insurance plan and/or you CPT 88305 -- \$120, CPT 88312 -- \$160, CPT 88313 -- \$110 or CPT 88342 -- \$190 per specimen as per policy guidelines. (The actual charge can only be determined after the pathologist reviews your specimen.) You may also receive further discounts if we are contracted with your insurance plan. One of our staff members will be happy to assist you if you have any questions regarding your pathology charges or this notice.