

CENTER FOR DIGESTIVE DISEASES  
& CARY ENDOSCOPY CENTER  
1120 SE CARY PARKWAY STE 204  
CARY, NC 27511  
PHONE (919) 854-0041  
FAX (919) 854-0049

**THIS IS VERY IMPORTANT! PATIENTS PLEASE MAKE SURE THAT YOU READ  
AND UNDERSTAND BEFORE SIGNING!**

Dear Patient,

We would like to take this opportunity to acquaint you with our office and billing procedures. It is our goal to satisfy you and make the financial aspects of your health care as convenient as possible. Therefore, as a courtesy to you, we file most insurance.

We will need a photocopy of your insurance card in order to process your claim. Without your card you will be responsible for full payment at the time that services are rendered. If your plan requires an annual deductible, we will need you to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

All patients who have insurance that requires an authorization (referral) are responsible for obtaining that authorization. When no authorization has been received prior to your appointment; you will be asked to either reschedule your appointment or be responsible for the full bill.

**Co pays or coinsurance will be due at the time services are rendered.** If you have a co pay or coinsurance you will be expected to pay it at every office visit. If you are scheduled for a procedure we will be responsible for obtaining authorization if it is needed. We will call your insurance company prior to your procedure to find out approximately what you will owe. We will inform you of what this amount is as soon as we can and **you will be expected to pay it on the day of your procedure.** If this amount includes a deductible and you believe that you have already met it, you will need to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

We require that you notify us twenty-four (24) hours in advance prior to any office cancellations, or forty-eight (48) hours in advance for a procedure cancellation or there will be a \$25.00 charge applied to the patient for the missed appointment and a \$50.00 charge for a missed procedure. The Physicians do reserve the right to cancel an appointment or procedure due to a conflict in scheduling.

We thank you for the opportunity to serve you!

**I have read, understand and accept the above billing and insurance procedures**

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Date

Date \_\_\_\_\_

### Patient Information

Thank you for choosing our office! In order to serve you well, we need the following information. Please print. All your medical information will be kept confidential.

#### Patient Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Person to contact in an emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

#### Insurance Information

##### Primary Insurance

Insurance Company \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (if other than patient) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Employer of Policy Holder \_\_\_\_\_  
Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ SS# \_\_\_\_\_

##### Secondary Insurance

##### Primary Insurance

Insurance Company \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (if other than patient) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Employer of Policy Holder \_\_\_\_\_  
Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ SS# \_\_\_\_\_

#### Assignment of Benefits and Authorization for Release of Information

I authorize release of any information concerning my or my child's health care, advice and treatment provide for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to my physician. I am financially responsible for non-covered expenses.

We are committed to providing you with the best possible care. As a service to you, we will file your insurance claim with necessary information in a timely fashion. Any outstanding balances after insurance pays will be billed to you for payment.

Please remember that your contract is between you and your insurance company to provide reimbursement for medical care. We cannot be responsible for unwarranted delays by your insurance company or HMO. If your coverage is not what you expect, please discuss it with insurance company or employer.

Most insurance policies will not cover the entire expense for your care. Please pay you co-pay at time of check out. In most cases, you will be required to make a deposit at the time you surgery is scheduled. For your convenience, we accept cash, checks, and most major credit cards.

#### Acknowledgement of Receipt of Privacy Notice

I understand that my physician or staff may share my / my child's medical information for treatment, billing, and healthcare business purposes. I acknowledge that I have been given information that describes how my / my child's medical information is used and shared.

**X** Signature of patient/parent \_\_\_\_\_ Date \_\_\_\_\_

*This signature is valid from this date and continues until revoked.*

**CENTER FOR DIGESTIVE DISEASES  
and CARY ENDOSCOPY CENTER, P.C.  
1120 SE CARY PARKWAY STE 204  
CARY, NC 27518**

**PHONE (919) 854-0041  
FAX (919) 854-0049**

Dear Patient,

One of our goals at the Center for Digestive Diseases is to meet the needs of our patients undergoing endoscopy procedures in a positive and professional manner. With this goal in mind, we have offered IV deep sedation provided by a nurse anesthetist with a drug called Propofol for our endoscopy and colonoscopy procedure patients since January of 2006. Deep conscious sedation reduces procedure pain and awareness to negligible amount. We have received an enthusiastic response to this deeper sedation and numerous "Thank You's" for this extra effort to meet the needs of our patients who "want to be knocked out completely!"

Unfortunately, your insurance company has not been as enthusiastic as our patients about this deep sedation. They will no longer pay for the continuous monitoring services of our nurse anesthetist or for the deeper sedative, Propofol. You may still receive this deeper sedation for an out of pocket cost of \$125.00, billed by Carolina Anesthesia after your procedure. If you do not wish this additional expense, moderate conscious sedation will be available as part of your procedure fee. Moderate conscious sedation is also given IV and provides adequate analgesia and sedation for most GI procedures while allowing the patient to cooperate with verbal commands and to communicate any discomfort they experience to the provider. Moderate conscious sedation induces an altered state of consciousness that minimizes pain and discomfort through the use of IV pain relievers and sedatives. A brief period of amnesia may erase most memory of the procedure.

Thank you for this opportunity to serve you,

Dr. H. Paul Singh, Dr. Raj Makam, and Dr. Douglas Pritchett  
Center for Digestive Diseases

---

**I do want to have the deep sedation offered by Carolina Anesthesia for my colonoscopy/endoscopy procedure and agree to pay an additional \$125.00 out of pocket; which will be billed to me by Carolina Anesthesia.**

---

**Signature**

---

**Date**

CENTER FOR DIGESTIVE DISEASES  
1120 SE CARY PARKWAY STE 204  
CARY, NC 27511  
PHONE (919) 854-0041  
FAX (919) 854-0049

It is the responsibility of the patient to make certain that our office has received a referral from the patient's primary care physician, for those insurance companies that require us to have a referral **prior** to seeing the patient. If the primary care physician's office has not sent us a written referral or if the patient doesn't bring in a referral by the PCP then we will not be able to see the patient for that day's visit, the appointment will need to be rescheduled or **by signing this letter entitles that patient to be seen at the cost of the patient for whatever the insurance company doesn't pay.**

---

**Patients Name (Print)**

---

**Patients Signature**

---

**Date**

---

**Witness Signature**

**CARY ENDOSCOPY CENTER**

Patient Name \_\_\_\_\_ Date of Procedure \_\_\_\_\_

Procedure to be Performed: \_\_\_\_\_

Chief Complaint/History Illness-Symptoms & Duration: \_\_\_\_\_

Medical and Surgical History: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

See H&P on Chart (H&P must be written within the past 30 days and updated if >7 days)

Physical Examination Date \_\_\_\_\_ Time \_\_\_\_\_ MD Signature \_\_\_\_\_

Normal Abnormal Specify

Head \_\_\_\_\_

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Breast \_\_\_\_\_

Abdomen \_\_\_\_\_

Genital/Pelvic \_\_\_\_\_

Rectal \_\_\_\_\_

Extremities \_\_\_\_\_

Neurological \_\_\_\_\_

Impression \_\_\_\_\_

Plan \_\_\_\_\_

Pre-Procedure Orders \_\_\_\_\_

Standing Orders: \_\_\_\_\_

Additional Labs/Orders: \_\_\_\_\_

Sign Operative Permit for: \_\_\_\_\_

Risks Benefits, complications explained to Patient/Guardian: Yes \_\_\_\_\_ No \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Pre-Sedation Assessment

ASA Classification (circle one)

Airway Assessment Performed \_\_\_ Yes

Class 1-Healthy pt, no medical problems FINDINGS: \_\_\_\_\_

Class 2-Mild Systemic \_\_\_\_\_

Class 3-Severe systemic disease, but not incapacitating \_\_\_\_\_

Class 4-Severe systemic disease that is a constant threat \_\_\_\_\_

to life

Class 5-Morbid pt who is not expected to survive without PRE-SEDATION PLAN: \_\_\_\_\_

the operation

\_\_\_\_\_ Moderate Sedation

Class 6-Brain Dead/Organ Donor \_\_\_\_\_

\_\_\_\_\_ Deep Sedation (per anesthesia)

Brief Procedure Note

Pre-op diagnosis \_\_\_\_\_ Post-op diagnosis \_\_\_\_\_

Procedure performed \_\_\_\_\_ Findings \_\_\_\_\_

Specimens \_\_\_\_\_ Complications \_\_\_\_\_

Sedation Level Achieved: \_\_\_\_\_ Moderate Sedation \_\_\_\_\_ Deep Sedation

Discharge Instructions: \_\_\_\_\_

\_\_\_\_\_ Discharge when Endoscopy criteria met

Post-Procedure

Orders: \_\_\_\_\_

\_\_\_\_\_ Standing Orders

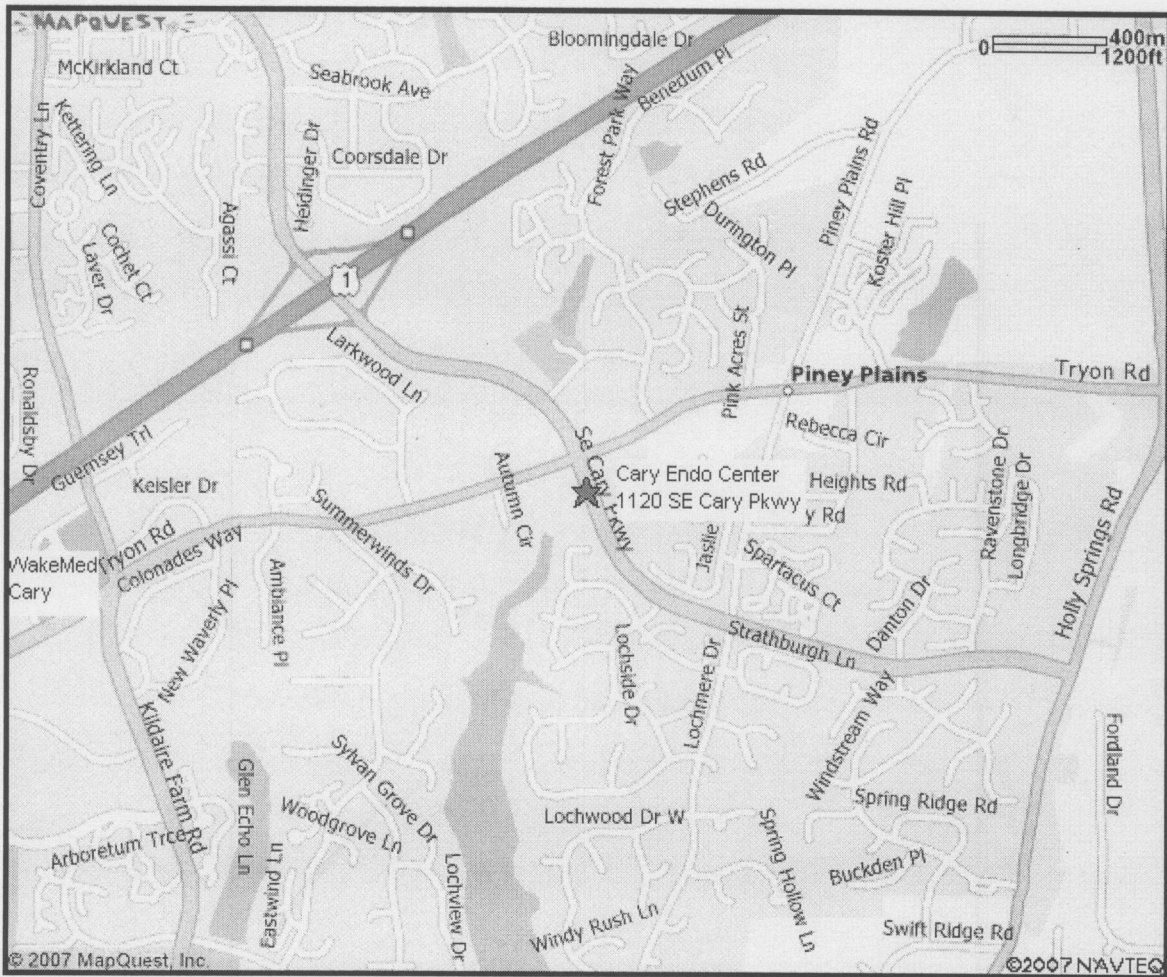
Post Procedure

Plan: \_\_\_\_\_

See Electronic Record: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

# Directions to Center For Digestive Diseases Cary Endo Center 1120 SE Cary Pkwy, Suite 204 Phone(919) 854-0041





**CARY DIGESTIVE DISEASES, PLLC**  
**INSURANCE PRECERTIFICATION FORM**

DATE CALLED FOR PRECERTIFICATION \_\_\_\_\_

TIME CALLED FOR PRECERTIFICATION \_\_\_\_\_

NAME OF PERSON YOU SPOKE WITH \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_ DOB \_\_\_\_\_

INSURANCE COMPANY- Aetna / BCBS/ UHC/ Cigna / Medcost/ Wellpath

INSURANCE NUMBER YOU CALLED \_\_\_\_\_

INSURANCE GROUP NUMBER \_\_\_\_\_

INSURANCE POLICY NUMBER \_\_\_\_\_

TYPE OF PROCEDURE OR TEST TO BE DONE WITH DIAGNOSIS

Colonoscopy 45378 / EGD 43239 \_\_\_\_\_

Screening for colon cancer V76.51 / Fa Hx colon cancer V16.0 / Hx of colon polyps V12.72

Fa Hx colon polyps V18.51 / \_\_\_\_\_

OUTPATIENT \_\_\_\_\_ INPATIENT \_\_\_\_\_ OFFICE \_\_\_\_\_

PERCERTIFICATION NEEDED YES \_\_\_\_\_ NO \_\_\_\_\_

PROCEDURE DATE \_\_\_\_\_ PLACE OF SERVICE \_\_\_\_\_

PRECERTIFICATION AUTHORIZATION NUMBER \_\_\_\_\_

COPAY FOR PROCEDURE \_\_\_\_\_ COPAY FACILITY \_\_\_\_\_

DEDUCTIBLE \_\_\_\_\_ MET \_\_\_\_\_

OUT OF POCKET \_\_\_\_\_ MET \_\_\_\_\_

INSURANCE PERCENTAGE \_\_\_\_\_ PT \_\_\_\_\_

FACILITY CHARGE APPLIED TO THE DEDUCTIBLE \_\_\_\_\_

Estimated Amount patient will owe at the time of service \_\_\_\_\_

Estimated Amount patient will owe Dr. Pritchett \_\_\_\_\_

The amounts above could change depending on how your insurance processes the claim.

Patient notified ON \_\_\_\_\_ ABOUT THE ABOVE \_\_\_\_\_

## What Type of Sedation will I Receive?

The choice of sedation that you receive for your procedure will be determined by you and our physician in cooperation with the nurse anesthetist. Please inform our healthcare team of any complications you have previously experienced with anesthesia or sedation.

All patients are monitored during the procedure using continuous pulse oximetry, heart monitoring, and intermittent blood pressure recording.

Conscious sedation is given IV and provides adequate analgesia and sedation for most GI procedures while allowing the patient to cooperate with verbal commands. This type of sedation induces an altered state of consciousness that minimizes pain and discomfort through the use of pain relievers and sedatives. Patients who receive conscious sedation usually are able to speak and respond to verbal cues throughout the procedure, communicating any discomfort they experience to the provider. A brief period of amnesia may erase most of the memory of the procedure.

Deep sedation is also given IV, most often with a drug called Propofol. Deep sedation will be administered by a nurse anesthetist. Most patients will not be aware of or experience any discomfort during the procedure. Patients who receive deep sedation are unable to speak or respond to verbal commands during the procedure. A separate bill from Carolina Anesthesia will be filed with your insurance carrier for deep sedation. For questions about Carolina Anesthesia billing information, call 1-800-951-7850.