

Center for Health and Cancer Prevention & Virginia Colonoscopy

1301 First Colonial Rd
Suite 201
Virginia Beach, VA 23454
PH: 757-412-4919

DATE OF APPOINTMENT: _____ CHECK-IN TIME: _____

APPOINTMENT TIME: _____

What is Included in this Packet:

1. Welcome to our Practice Letter
2. Patient Registration Form
3. Medication Reconciliation Form
4. Medical History Questionnaire
5. Medical Records Release
6. Written Disclosure and Cancellation Form
7. List of Insurances we **DO** and **DO NOT** Participate With

Please call us at (757) 412-4919 if you haven't received any of these forms. Please visit our website at <https://www.virginiacolonoscopy.com> for informational videos on what to expect the day of your procedure and preparation advice for your colonoscopy or endoscopy.

******Please arrive 30 minutes prior to your appointment with your ID, Insurance Cards, and Completed Paperwork. Ensure that you have registered to the Patient Portal prior to your check-in******

Email address Patient Portal invitation was sent to:

Important: Please Read

Colonoscopy and endoscopy are very safe procedures. In experienced hands, the overall complication rate is less than 1 in 1,000 (serious complications include but are not limited to: bleeding, perforation (tearing of the bowel wall), and cardiac or respiratory complications). Colonoscopy is therefore about 99.99% safe. Colon cancer on the other hand affects 1 in 19 people in the United States, with a 40% mortality rate in the first 5 years. Colonoscopy has been shown in some studies to reduce the risk of developing colon cancer by over 90%. While there is a very small but definite risk of serious complication during a colonoscopy, it is overshadowed greatly by the risk and complications of colon cancer. Dr. Berger and the anesthetist will answer any further questions you may have regarding your procedure prior to the procedure. If you have any immediate questions regarding the risks of the procedure, please be sure to ask our staff.

Virginia Colonoscopy & Center for Health and Cancer Prevention
1301 First Colonial Rd, Suite 201, Virginia Beach, VA 23454
Tel: 757-412-4919 Fax: 757-412-4898
<https://www.virigniacolonoscopy.com>

Welcome to our Practice!

Thank you for choosing Virginia Colonoscopy & Center for Health and Cancer Prevention. We would like to take this opportunity to provide you with some general information about our practice.

Medical service provision: Dr. Keith Berger or Dr. Beth Jaklic will be performing your procedure. Dr. Berger is a board-certified gastroenterologist with over 30 years of experience in clinical practice. Dr. Jaklic is a board-certified Colon and Rectal Surgeon with over 19 years of experience in clinical practice. Our office is dedicated exclusively to screening and prevention of colorectal and gastrointestinal cancers. We are committed to providing high quality, cost effective, safe, and accessible service aimed at reducing or preventing GI cancer risk. Because of our specialized expertise, all general patient management issues will be handled through your primary care physician. Dr. Berger and Dr. Jaklic do not actively treat patients, manage hospital admissions, or otherwise manage care beyond providing diagnostic consultation and performing diagnostic services such as colonoscopy and endoscopy.

Change in Medical History: We are committed to providing you with safe, high-quality care. If your medical history- such as a new diagnosis, a change in medication regimen or a recent hospitalization has changed since the time you first scheduled your procedure, please notify us prior to your appointment so we can update your records.

Patient Rights and Responsibilities: As our patient you have rights and responsibilities. This policy is available to you upon request from our office staff at any time before, during or after your visit. It is also available for review in our front lobby area.

Appointment details: Please bring your driver license and insurance card with you at the time of service. You can expect to be in our office for approximately 1 ½ to 2 hours. We strive to run on schedule. However, because we are committed to providing each patient with the individual attention he or she requires, on occasion we may run into circumstances beyond our control. We ask for your patience and will keep you informed if a delay occurs. If your procedure involves sedation, be sure that you arrange a family member or friend to drive you home. Once you arrive home, you should plan on resting quietly for the remainder of the day.

Appointment preparation: If you are having a colonoscopy, you will be drinking an oral preparation solution to cleanse your system. This solution works differently on each patient therefore it may take minutes or hours to take effect. Please make sure you always have quick access to a bathroom after taking the prep solution.

The success of your colonoscopy is highly dependent upon careful pre-procedure preparation. Please be sure to refer to the patient instructions for detailed instructions.

Your privacy: We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care and services you receive to document your care and reference by you and your primary care physician as well as to comply with certain legal requirements. Protection of your medical information applies to all records of your care generated by this office, whether made by office personnel or the physician. You may request a copy of our full confidentiality statement for your review.

Still have questions?: We are always happy to provide answers and alleviate any of your concerns. We are available Monday-Friday 8:00 AM to 4:00 PM to answer any questions you may have about your upcoming appointment. **Please do not hesitate to call us-** our goal is to ensure that your experience with our practice is as stress- free as possible!

Have a grievance or complaint?: We are committed to providing the highest quality of care. If you have a complaint or grievance relating to your experience at CHCP, please contact us at (757) 412-4919 and we will provide you with information about how to officially file said complaint and/or speak with our Manager to ensure that your concerns are addressed.

Please note: We are required by law to notify you that this facility **does not** honor Advanced Directives with regards to Do Not Resuscitate clauses.

VIRGINIA COLONOSCOPY & CENTER FOR HEALTH AND CANCER PREVENTION

Patient Registration

Patient Name: Last: _____ First: _____ M.I. _____

Address/City/State/Zip: _____

Phone # _____ Cell Phone # _____ Sex: Male / Female

Email: _____ Birthdate: _____ Number of Children: _____

Ethnicity: Hispanic or Latino / Not Hispanic or Latino Marital Status: Single / Married / Widowed / Divorced

Race: Asian/ Black or African American/ White Primary Language: _____

Rate your overall health on a scale of 1-10 (with 10 being the best) _____

What do you find most stressful? _____

Any other health concerns not covered above? _____

Any specific health goals you have? _____

Any other questions or concerns you have? _____

What are your hobbies/interests? _____

How did you hear about us? _____

Y N Have you tried losing weight?

Y N Are you interested in losing weight?

Y N Have you succeeded?
Amt. Lost: _____ lbs

Y N Are you interested in developing a
health program?

Employer _____ Work Phone # _____

Employer Address _____

Spouse _____ Birthdate _____ Phone # _____

Spouse Employer _____ Phone # _____

Emergency Contact / Relation: _____ Phone# _____

We will file your insurance; however, **you are responsible for deductibles, co-payments and non-covered services including lab diagnostic fees. We send lab specimens to either Dominion Pathology, Aurora Diagnostics, Sentara or LabCorp. Please let us know if you have a preferred lab for us to send your samples to.**

***** Please contact your insurance company to verify coverage information.*****

Primary Insurance _____ Policy# _____

Subscriber Name _____ Group# or Name _____

Relationship to Subscriber: Self / Spouse / Child / Other _____

Secondary Insurance _____ Policy# _____

Subscriber Name _____ Group# or Name _____

Relationship to Subscriber: Self / Spouse / Child / Other _____

I request payment of authorized health insurance benefits be made to me or on my behalf to the providers at Virginia Colonoscopy and CENTER FOR HEALTH & CANCER PREVENTION for services rendered to me. In the event of default, I agree to pay the balance and all costs of collection, including attorney's fees in the amount of 33.5% of the total amount due when turned over to collections. Insurance authorization and assignment of benefits is effective until revoked. **If health care workers expose themselves to my body fluids, I agree to have my blood tested for any infectious disease, which might be transmitted.**

Patient Name: _____ DOB: _____ Date: _____

MEDICATION RECONCILIATION FORM

Allergies (Medications, Foods, Dyes, or Latex): _____ No Known Allergies

Active Medication List: List below all medicines, vitamins, and herbal products						AT DISCHARGE	
<input type="checkbox"/> Confirmed with patient in preop						Continue at Discharge	Do NOT Take upon Discharge
Dosing Information is Required if Possible							
Medication Name	Dosage	Route	Frequency	Last Dose	Reason for Med		

Please Check if Taking No Medications
 Information obtained by:
 Patient
 Family/Caregiver

New Medicines Prescribed for Patient at Time of Discharge	Notes:

MD Signature _____ PACU Signature _____ Copy Given to Patient

CENTER FOR HEALTH AND CANCER PREVENTION MEDICAL HEALTH QUESTIONNAIRE

Patient's Name: _____ DOB: _____ Date: _____

<u>REASON FOR VISIT</u>	
<input type="radio"/> Colon cancer screening	<input type="radio"/> Abdominal pain
<input type="radio"/> Personal history of colon cancer/colon polyps	<input type="radio"/> Difficulty swallowing
<input type="radio"/> Family history of colon cancer/colon polyps	<input type="radio"/> GERD/Reflux/Heartburn
<input type="radio"/> Positive FIT test or Cologuard	<input type="radio"/> Other

<u>PAST AND PRESENT MEDICAL HISTORY</u>	
Have you ever had a: Colonoscopy <input type="radio"/> YES <input type="radio"/> NO	Endoscopy (EGD) <input type="radio"/> YES <input type="radio"/> NO
If yes: When _____ Where _____ Result _____	
Have you ever had problems with Propofol sedation or other anesthesia? <input type="radio"/> YES <input type="radio"/> NO	
Have you ever had a difficult airway intubation? <input type="radio"/> YES <input type="radio"/> NO	
Have you been diagnosed (or are currently being treated) for the following?	
<u>Colon/Rectal</u>	<input type="radio"/> No Known Issue
<input type="radio"/> Colon/Rectal cancer	<input type="radio"/> Diverticulitis/Diverticulosis
<input type="radio"/> Colon resection	<input type="radio"/> GI/Rectal bleed
<input type="radio"/> Polyps	<input type="radio"/> Ulcerative colitis
<input type="radio"/> Crohn's disease	<input type="radio"/> Chronic constipation
<input type="radio"/> Chronic diarrhea	
<u>Esophageal/Throat (for EGD)</u>	<input type="radio"/> No Known Issue
<input type="radio"/> Esophageal cancer	<input type="radio"/> Gastritis
<input type="radio"/> Gastric bypass	<input type="radio"/> Esophagitis
<input type="radio"/> Upper GI bleed	<input type="radio"/> Epigastric pain
<input type="radio"/> Anemia	<input type="radio"/> Peptic (Stomach) ulcer
<input type="radio"/> Barrett's Esophagus	<input type="radio"/> GERD/Reflux
<input type="radio"/> Hiatal hernia	<input type="radio"/> Nausea/vomiting
<input type="radio"/> Unexplained weight loss	
<u>Cardiac/Heart</u>	<input type="radio"/> No Known Issue
<input type="radio"/> Pacemaker	<input type="radio"/> Coronary artery bypass
<input type="radio"/> Defibrillator	<input type="radio"/> Stent placement
<input type="radio"/> Congestive heart failure	<input type="radio"/> Cardiac ablation
<input type="radio"/> Artificial heart valve	<input type="radio"/> Coronary artery disease
<input type="radio"/> Aortic aneurysm	<input type="radio"/> Heart attack
<input type="radio"/> Arrhythmia	<input type="radio"/> Stroke
<input type="radio"/> Atrial fibrillation/A-fib	<input type="radio"/> Fainting
<input type="radio"/> High blood pressure	<input type="radio"/> High cholesterol
<u>Pulmonary/Lung</u>	<input type="radio"/> No Known Issue
<input type="radio"/> Oxygen dependent	<input type="radio"/> Chronic asthma (daily inhaler use)
<input type="radio"/> Shortness of breath	<input type="radio"/> Sleep apnea with CPAP or BIPAP
<input type="radio"/> Emphysema	<input type="radio"/> Blood clots
<input type="radio"/> Pulmonary embolism/PE	<input type="radio"/> Deep vein thrombosis/DVT

<u>Renal/Kidney</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Chronic kidney disease	<input type="radio"/> Stage _____	<input type="radio"/> On dialysis	
<u>Neurological</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Seizure	<input type="radio"/> Epilepsy	<input type="radio"/> Dementia/Alzheimer's	
<input type="radio"/> Parkinson's disease	<input type="radio"/> Brain aneurysm	<input type="radio"/> ALS	
<u>Endocrine</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Diabetes Type I	<input type="radio"/> Diabetes Type II	<input type="radio"/> Graves' Disease	
<input type="radio"/> Hashimoto's Disease			
<u>Contagious Disease Exposure</u>			<input type="radio"/> No Known Issue
<input type="radio"/> HIV	<input type="radio"/> TB	<input type="radio"/> Hepatitis B or C	
<u>Autoimmune Disease</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Multiple Sclerosis (MS)	<input type="radio"/> Polymyalgia Rheumatica (PMR)	<input type="radio"/> Lupus	
<input type="radio"/> Rheumatoid Arthritis (RA)			
Other chronic disease or health issues? _____			
<u>Abdominal/Stomach</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Cholecystectomy	<input type="radio"/> Abdominoplasty/Tummy Tuck	<input type="radio"/> Pancreatitis	
<input type="radio"/> Appendectomy	<input type="radio"/> Abdominal aortic aneurysm	<input type="radio"/> Liver disease	
<input type="radio"/> Hysterectomy	<input type="radio"/> Hernia repair	<input type="radio"/> Abdominal pain	
<input type="radio"/> Cesarean delivery	<input type="radio"/> Gas/bloating		
<u>Mobility</u>			<input type="radio"/> No Known Issue
<input type="radio"/> Assistance required to dress or walk		<input type="radio"/> Cane, walker, or wheelchair dependent	
<input type="radio"/> Occasionally uses a cane			
<u>SOCIAL HISTORY</u>			
Do you drink alcohol?			<input type="radio"/> YES <input type="radio"/> NO
If yes, approximately how many drinks per week?			
Do you smoke and/or vape tobacco or CBD?			<input type="radio"/> YES <input type="radio"/> NO
If yes, approximately how much per week?			
Are you currently taking any anticoagulant/antiplatelet (blood thinner)?			<input type="radio"/> YES <input type="radio"/> NO
If yes, which one(s):			
<i>ANTICOAGULANT</i>			
<input type="radio"/> Coumadin (warfarin)	<input type="radio"/> Eliquis (apixaban)	<input type="radio"/> Xarelto (rivaroxaban)	
<input type="radio"/> Pradaxa (dabigatran)	<input type="radio"/> Lixiana (edoxaban)	<input type="radio"/> Heparin	
<i>ANTIPLATELET</i>			
<input type="radio"/> Plavix (clopidogrel)	<input type="radio"/> Brilinta (ticagrelor)	<input type="radio"/> Effient (prasugrel)	
<input type="radio"/> Cilostazol/dipyridamole	<input type="radio"/> Aspirin		
Height: _____ ft. _____ in. Weight: _____ lbs. BMI: _____			

**CENTER FOR HEALTH AND CANCER PREVENTION
& VIRGINIA COLONOSCOPY**

1301 First Colonial Rd, Suite 201
Virginia Beach, VA 23454
Phone 757-412-4919
Fax 757-412-4898

MEDICAL RECORDS RELEASE

Patient

Name _____

Last First M.I. Maiden

Birthdate _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION to your Primary Care Physician and/or your Insurance Carrier only is hereby given to Dr. Keith Berger and Dr. Beth Jaklic with Virginia Colonoscopy & Center for Health & Cancer Prevention.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION to Virginia Colonoscopy & Center for Health and Cancer Prevention also is given to other physicians, healthcare facility or when records are requested for the purpose of continued medical care by Dr. Keith E. Berger and Dr. Beth Jaklic.

Signature of Patient or Guardian _____ **Date** _____

*****Authorization is effective until revoked by the patient.**

If you want any family member or friend to have access to your records, please fill out the section below:

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____; to be sent to the following person or company.

Person/Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

Signature of Patient or Guardian _____ **Date** _____

This authorization is valid until: _____
Date

**Center for Health and Cancer Prevention
& Virginia Colonoscopy**

1301 First Colonial Road Suite 201
Virginia Beach, Virginia 23454

WRITTEN DISCLOSURE FORM

Virginia law requires that we disclose to you our investment interest in the entity to which you are being referred for medical treatment. Keith E. Berger, M.D. and Beth Jaklic, M.D. have an investment interest in Virginia Colonoscopy & Center for Health and Cancer Prevention, PC, a Virginia limited liability company (the "Company") with its principal place of business located at 1301 First Colonial Rd, Virginia Beach, VA. The Company wholly owns Virginia Colonoscopy & Center for Health and Cancer Prevention (the "Surgery Center") located at 1301 First Colonial Rd.

You have the right to obtain the items or services for which you have been referred from the Surgery Center or from the provider or supplier of your choice.

We have provided for you below the names and addresses of two alternative sources of health care items or services available to you.

Gastroenterology, Ltd.

1717 Will O Wisp Dr # 200, Virginia Beach, VA 23454

Gastroenterology Consultants, Ltd.

1925 Glenn Mitchell Dr #102, Virginia Beach, VA 23454

To acknowledge your receipt of this written disclosure form, we request that you please sign this letter on the space provided below so that we may have an accurate record that you have been informed pursuant to Virginia law of our investment interest in the Surgery Center to which you are being referred.

Patient's Initials

ELECTRONIC MEDICAL RECORD

Our practice uses AthenaNet a prescription system and electronic medical record that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past.

Our practice has a policy on patient rights and responsibilities and privacy rights. You may request a copy of these policies at any time from our front office staff.

Patient's Initials

CANCELLATION POLICY

Please note that, based on your reserving a date and time for your procedure, we will reserve office time, support staff and a nurse anesthetist for your procedure. Due to the nature of the procedure and the necessary prep time, it is difficult or impossible to reassign your appointment time if you choose to cancel. Virginia Colonoscopy & CHCP reserves the right to charge a **\$250 cancellation fee if a PROCEDURE is cancelled less than 5 business days** prior to the date of your procedure. Virginia Colonoscopy and Center for Health and Cancer Prevention reserves the right to charge a **\$50 cancellation fee if a CONSULTATION is cancelled less than 24 hours prior to your appointment.**

Patient's Initials

SPECIMEN LAB FEES

Biopsies or specimens may be collected during your procedure. These samples are sent to off-site labs (Dominion Pathology Laboratories, LabCorp, Sentara, or Aurora Diagnostics). **They are separate companies and thus any bills or fees originating from the testing of these samples is your responsibility.** If you have any questions regarding your statement, please call the company where the bill originated from. If you prefer which lab your samples should be sent to, please let us know when you check in for your procedure.

Patient's Signature and Date

VIRGINIA COLONOSCOPY & CENTER FOR HEALTH AND CANCER PREVENTION

Keith Berger, MD Beth Jaklic, MD Kelly Lewis, PA Carolyn Aros, PA
Ph. #: (757) 412-4919 Fax #: (757) 412-4898

Attention Patients

Insurances we **DO** participate with:

Insurance Provider

Humana
BCBS
Tricare
Aetna
United Healthcare
Optima
Medicare
Cigna

***Secondary Insurance Providers*

Insurance Package

PPO and PFFS
HealthKeepers and all other plans except Medicaid
Select and Tricare for Life
All plans except Medicaid
PPO, Choice, Choice Plus
All plans except Medicaid

We accept all secondary insurances

We **DO NOT** participate with the following insurances listed below. If you come in for the procedure and you have one of these insurances, we **will not be able to see you** or **you will have to pay for the service** as a self-pay patient prior to your appointment.

Insurances we **DO NOT** participate with:

Insurance Provider

Humana
Tricare
Aetna
United Healthcare
Magellan
Optima
AARP
Molina
BCBS

Insurance Package

HMO
Prime
Better Health
HMO, Community Care, and Dual Complete
Complete Care of VA
Family Care and Community Care
Medicare Complete
Medicare Advantage Plans and Medicaid
Commonwealth Coordinated Care Plus and
HealthKeepers PLUS (Medicaid version)

Please make sure to check your insurance card and **call us prior to your appointment** at (757) 412-4919 if you have any questions or concerns.

SELF-PAY DISCOUNT

If you are interested in our self-pay, same-day, discount, please contact us at (757) 412-4919 or email us at info@chcponline.com for more information.

Thank you,

Virginia Colonoscopy & Center for Health and Cancer Prevention

Patient Signature

Date