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: _____

PROCEDURE TIME: _____

What is Included in this Packet:

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

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 #:**_____

Email: _____ **Birthdate:** _____ **Number of Children:** _____

Social Security Number: _____ **-** _____ **-** _____ **Sex:** Male / Female

Primary Care Provider's Name: _____ **Phone #:** _____

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 you 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 _____

VIRGINIA COLONOSCOPY
& CENTER FOR HEALTH AND CANCER PREVENTION, LLC

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**	
☐ **Confirmed with patient in preop** **Nurse Signature**						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
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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

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 & **C**enter for **H**ealth and **C**ancer **P**revention, 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 23456

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

INSURANCE AUTHORIZATION

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 and 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. I understand that insurance authorization and assignment of benefits is effective until revoked. I agree to provide accurate insurance information at time of service.

_____
Patient's Initials

ELECTRONIC MEDICAL RECORD

Our practice uses Express Scripts as a prescription system and Athenanet as an electronic medical record that allows prescriptions and related information to be exchanged between your providers and the pharmacy. The information sent between these systems may include details of any, and all, prescription drugs that you are 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

BLOODBORNE PATHOGEN POLICY

In the event that a health care worker is exposed to my bodily fluids, I agree to have my blood tested for any infectious disease, which might be transmitted, as soon as possible.

_____
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	**Insurance Package**
Humana	PPO and PFFS
BCBS	HealthKeepers and all other plans except Medicaid
Tricare	Select and Tricare for Life
Aetna	All plans except Medicaid
United Healthcare	PPO, Choice, Choice Plus
Optima	All plans except Medicaid
Medicare	
Cigna	
***Secondary Insurance Providers*	*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	**Insurance Package**
Humana	HMO
Tricare	Prime
Aetna	Better Health
United Healthcare	HMO, Community Care, and Dual Complete
Magellan	Complete Care of VA
Optima	Family Care and Community Care
AARP	Medicare Complete
Molina	Medicare Advantage Plans and Medicaid
BCBS	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

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Patient Signature **Date**